



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

April 2, 2018

Supplemental Nutrition Assistance Program Manual - Volume V

Transmittal #22

This transmittal contains revised elements used to determine eligibility and benefit amounts for the Supplemental Nutrition Assistance Program (SNAP). This transmittal also includes new or revised provisions, including clarification on bilingual requirements and on liability when a claim is discharged through bankruptcy. This transmittal clarifies when a penalty is applied to the SNAP case when there is an act of noncompliance with another means tested program.

The provisions of this transmittal are effective May 1, 2018 for all SNAP actions taken on or after May 1, 2018.

The certification manual and this transmittal are available at <https://snapmanual.dss.virginia.gov/FoodStampManual/mainpage.jsp>.

Changes are noted for the following sections:

Chapter	Significant Changes
Part I Pages 3, 8-10	Bilingual requirements were updated to indicate that the local agency must provide staff, interpreters, program informational activities and certification materials in English and in the household's designated language. The Virginia Case Management System (VaCMS) currently prints this information in English and Spanish. If the household indicates Spanish as the preferred language, the worker must provide all certification materials in Spanish.

Chapter	Significant Changes
Part II Appendix II Pages 1-3	Clarification provided on the procedures involving the Virginia Combined Application Project (VaCAP) and change in the VaCAP benefit allotments where the high benefit amount is \$140 and the low benefit amount is \$66.
Part XII Page 12	Clarification provided that no penalty is applied to the SNAP case when the TANF case closes for failing to sign the VIEW Agreement of Personal Responsibility.
Page 19	The chapter on Transitional SNAP benefits was updated to reflect that transitional benefits will not apply if a TANF case is closed for failing to sign the VIEW Agreement of Personal Responsibility.
Part XV Appendix I Page 2	The list of exempt localities was updated to reflect the addition of two localities—Dinwiddie and Highland—that will be exempt from time-limited benefits effective May 1, 2018-April 30, 2019.
Part XVII Page 12	The chapter on recipient claims was updated to clarify that if a claim is discharged in a bankruptcy, then all liable persons are released from liability unless contrary to the court order.
Page 16-17	The chapter on submission of payments was updated to provide a new mailing address to send consolidated checks. Also, new email addresses were provided for local agencies to indicate they received no cash or state tax intercept payments.
Part XX Page 17	The monthly income limit, the full and half-month benefit allotment for the Disaster SNAP program was updated.

Chapter	Significant Changes
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Part XXIV

Pages 1-16

Pages 17-26

The updated versions of the Application for Benefits and the Renewal Application for AG, SNAP, and TANF have been added.

Questions about this transmittal should be directed to regional program consultants or Nikole Cox at nikole.cox@dss.virginia.gov or at (804) 726-7270.

S. Duke Storen
Commissioner

Attachment

PART I	INTRODUCTION	
<u>CHAPTER</u>	<u>SUBJECT</u>	<u>PAGES</u>
A.	PURPOSE OF THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM	1
B.	HISTORY OF THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM	1
C.	BENEFIT ISSUANCE AND USE	1-2
D.	PERSONNEL AND OFFICE OPERATIONS	3
E.	NONDISCRIMINATION	3
	1. Discrimination Complaints	4-5
	2. Public Notification	5
	3. Annual Training	5
	4. Reasonable Accommodations	5-6
F.	COLLECTION OF RACIAL/ETHNIC GROUP DATA	6
G.	RETENTION OF RECORDS	6-7
H.	DISCLOSURE OF INFORMATION	7-8
I.	PROGRAM INFORMATIONAL ACTIVITIES	8
	1. Booklets/Pamphlets	8-9
	2. Posters	9
	3. Other Required Activities	9
J.	CERTIFICATION MATERIALS	9
K.	FAMILY ASSESSMENT	10
L.	PRUDENT PERSON CONCEPT	10
M.	PRE-APPLICATION ELIGIBILITY DETERMINATION/ DISCUSSION PROHIBITED	10
APPENDIX I	FIPS CODE DIRECTORY	1
APPENDIX II	VIRGINIA DEPARTMENT OF SOCIAL SERVICES PRACTICE MODEL	1-2

D. PERSONNEL AND OFFICE OPERATIONS (7 CFR 272.4(a))

The local agency must provide qualified employees necessary to take prompt action on all applications. Local agency employees who certify households for participation in the Supplemental Nutrition Assistance Program must meet the same personnel standards as those used by the local agency for personnel who certify applicants for benefits under the federally aided public assistance programs. Only qualified local agency employees may conduct the interview of applicant households required by Part II.D and determine the household's eligibility or ineligibility and the level of benefits. In addition, only authorized employees or agents of the state or local agency, or a local issuing agency may have access to EBT cards or the EBT administrative terminal.

The local agency must provide timely, accurate, and fair service to SNAP applicants and participants. Each local agency must establish office procedures and operations that accommodate the needs of the populations it serves. Populations with special needs may include households with elderly or disabled members, homeless households, and households with members who work during normal office hours. **The local agency must provide staff and interpreter services to households with limited English proficiency.**

E. NONDISCRIMINATION

Federal law and the Virginia Human Rights Act, Virginia Code §2.2-2632 et seq., bar discrimination on the basis of age, race, sex, disability, religious creed, national origin, and political belief. The following civil rights laws apply for SNAP:

- The Age Discrimination Act of 1975, 42 U.S.C. §6101 et seq.
- Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §794
- The Americans with Disabilities Act of 1990, 42 U.S.C. §12101 et seq.
- Title VI of the Civil Rights Act of 1964, 42 U.S.C. §2000d et seq.

Virginia has established procedures to ensure fair and equitable treatment of applicants and recipients of public assistance. The local department of social services must assure that no person will be subjected to discrimination on the grounds of age, race, color, sex, disability, religious creed, national origin, or political belief.

Key Principles

Compliance with these laws assures that equal opportunity exists for persons with disabilities to benefit from all aspects of public assistance programs, including access to the proper support services to enable such individuals to work and to keep their families healthy, safe and intact. "Individualized treatment" and "effective and meaningful opportunity" are two key principles that underlie the bar on discrimination against people with disabilities.

Individualized Treatment

"Individualized treatment" requires that individuals with disabilities be treated on a case-by-case basis consistent with facts and objective evidence. Individuals with disabilities must not be treated on the basis of generalizations and stereotypes.

2. Employees of the Comptroller General's Office of the United States for audit examination authorized by any other provision of law;
3. Local, state, or federal law enforcement officials upon a written request to investigate an alleged violation of the Food and Nutrition Act or regulations. The written request must include the identity of the individual requesting the information and the authority to do so, the violation being investigated, and the identity of the person on whom the information is requested.
4. Law enforcement officials upon notification that an individual is fleeing prosecution or imprisonment, is in violation of parole or, that an individual has information needed to conduct an investigation of a felony or parole violation. The individual's address, Social Security number, and photograph, if available, must be disclosed upon written request. (The agency may not disclose scheduled appointment dates or times.)
5. The parent locator service to assist in the Child Support Enforcement Program under Title IV-D, upon request; and
6. Persons directly connected with the verification of immigration status of aliens applying for SNAP benefits through SAVE to the extent the information is necessary to identify the individual for verification purposes.

If there is a written request by a responsible member of the household, its currently authorized representative, or a person acting on its behalf, the household representative must be allowed to review material and information contained in the case file, during normal business hours. The agency may withhold confidential information, however, such as the names of individuals who have disclosed information about the household without the household's knowledge, or the nature or status of pending criminal prosecutions.

All local offices of the Department of Social Services must maintain state regulations and manuals that affect the public for examination by the public on regular workdays during regular office hours.

I. PROGRAM INFORMATIONAL ACTIVITIES (7 CFR 272.5)

SNAP information must be available to **the** applicant and recipient households **in English and the household's designated language**. Program information includes the rights and responsibilities of households. This information may be conveyed through publications, telephone hotlines, and face-to-face contacts.

1. Booklets/Pamphlets

a. *Virginia Social Services – Benefit Programs* information pamphlet - Applicants may receive this pamphlet at the time of each new application. The EW may provide the pamphlet at each reapplication or recertification if the household no longer has a copy of the pamphlet

- b. *Appeals and Fair Hearings* pamphlet – Local agencies may provide this pamphlet with adverse action notices to reduce or terminate benefits or when applications are denied.
- c. *Virginia EBT Questions and Answers* pamphlet and the EBT wallet card – The local agency or the EBT vendor must provide EBT materials to EBT card recipients upon the initial or replacement issuance of the EBT card. The local agency must provide these EBT materials upon request after the issuance of the EBT card.

2. Posters

These posters must be prominently displayed where SNAP applications are taken:

- a. "And Justice for All"
- b. "Your SNAP Rights"

3. Other Required Activities

- a. The agency must provide an explanation of household rights when applicants request information about the Supplemental Nutrition Assistance Program. The agency may provide a verbal explanation or it may provide the *Know Your Rights When Applying for SNAP Benefits* flyer if the applicant is able to read and comprehend the form in English or other available languages.
- b. The agency must complete the *SNAP - Hotline Information* form and provide it to each applicant on the day the applicant files a new application, a reapplication, or a late recertification application.
- c. The local agency must make an effort to answer general or specific questions related to the Supplemental Nutrition Assistance Program from persons expressing an interest in applying for program benefits. The agency may refer callers to appropriate agency personnel, and if those persons are not available, the agency must arrange to return the call. If it is not possible to return the call, the agency must advise the caller to return the call at a prearranged time when the appropriate personnel will be available to answer the questions.

J. **CERTIFICATION MATERIALS (7 CFR 272.4)**

SNAP information must be available to the applicant and recipient households in English or in the household's designated language. Certification materials include the SNAP application or renewal forms, change report form and notices.

K. FAMILY ASSESSMENT

Benefit programs are designed to provide income support benefits to assist families who are unable to provide the necessities of life and maintain minimum standards of health and well-being through their own efforts. Gathering relevant information about a family's situation and assessing that information against the eligibility for benefit programs are the basis for making the eligibility determinations. This process also includes an assessment of need for service programs and other resources to assist the family, which includes following the Practice Model contained in Appendix II of Part I. If other needs exist, the eligibility worker must refer the family for appropriate services or resources within the agency or community.

L. PRUDENT PERSON CONCEPT

This manual provides guidelines for the Supplemental Nutrition Assistance Program. Material presented here is often broad to allow certification staff sufficient flexibility to make reasonable judgements in evaluating individual household circumstances to determine SNAP eligibility and benefit level.

It is not possible to have every potential situation observed in managing a caseload addressed in this manual so, the eligibility worker must determine what is reasonable, i.e., the prudent person concept. The eligibility worker must exercise reasonable judgement based on experience, knowledge of the program and logic. The prudent person concept does not eliminate or replace eligibility requirements or actions. The worker must sufficiently document the case file to allow supervisory staff, appeals officers, reviewers, and colleagues to be able to understand case actions as well as to permit self-review.

M. PRE-APPLICATION ELIGIBILITY DETERMINATION/DISCUSSION PROHIBITED

SNAP eligibility guidance must be applied to the facts of a specific application submitted by a household; the interview with the household based on the submitted application; and any additional information supplied by an applying household. Prior to receipt of an application, local department of social services employees must not provide advice or answers to hypothetical situations from applicants, potential applicants, or those acting on behalf of others. Until a complete application is received by the local department of social services, an interview is conducted, and verifications are received, the local department of social services cannot be sure it has all the relevant facts. It is appropriate, however, to explain program eligibility criteria.

THE VIRGINIA COMBINED APPLICATION PROJECT

The Virginia Combined Application Project (VaCAP) is a partnership between the Virginia Department of Social Services (VDSS), the Social Security Administration (SSA), and the Food and Nutrition Service (FNS) of the United States Department of Agriculture (USDA). This demonstration project streamlines the application process for the Supplemental Nutrition Assistance Program (SNAP) for elderly Supplemental Security Income (SSI) recipients and increases their SNAP participation. **It does not replace all SNAP eligibility criteria but streamlines certain criteria as defined in this appendix.**

Eligible VaCAP participants are identified through a cross match of the State Data Exchange (SDX) and the current SNAP caseload. SDX information is also used by VDSS to update eligibility for SSI recipients monthly after approval for VaCAP. Applications and recertification applications are mailed monthly.

VDSS notifies applicants that they have the option to apply for and participate in the regular, ongoing SNAP, and have the case managed through the local department of social services (LDSS) according to standard policies and procedures.

VaCAP Eligible Household:

To be eligible for VaCAP, an individual must be identified through the SDX as one who:

- Receives SSI;
- Lives in Virginia;
- Is 65 years of age or older;
- Is not institutionalized;
- Meets Federal Living Arrangement A (FLA="A"); and
- Has no earned income.

In addition, the individual:

- Is not currently receiving SNAP; and
- Purchases and prepares food separately.

VaCAP Application Procedures:

VDSS will mail a simplified application to SSI recipients who meet the eligibility criteria and who are not currently participating in SNAP. Applicants must sign and return the application to the LDSS in the city or county of residence. If the applicant does not return the application within 30 days, a second application is mailed. If the second application is not returned, **an application will be mailed in 12 month intervals until a total of five applications are mailed.** Individuals may apply for VaCAP if it is determined they meet the VaCAP criteria but, did not receive a computer generated application because they had already received **five** applications, **or an application had been mailed less than 12 months ago**, or because they were participating in regular SNAP.

Upon receipt of the VaCAP application, the LDSS must screen the application to ensure:

- application is signed;

- the applicant is not already participating in SNAP (eligibility system inquiry); and
- the applicant is not disqualified from participating in SNAP (eDRS inquiry).

VaCAP applications are not screened for expedited processing nor screened for death and incarceration. Death and incarceration are routinely reported in the SDX data.

If shelter expenses are not marked on the application, the LDSS must process the application using the lower shelter expense.

VaCAP participants may request that their VaCAP case be closed in order to apply for regular SNAP benefits. Participants receiving regular SNAP benefits may request that their case be changed to VaCAP if it is determined they meet all of the VaCAP criteria except for not currently receiving SNAP.

VaCAP Interview Procedures:

Unless the applicant requests help with the application, there is no certification interview.

VaCAP Verification:

The SDX provides verification of eligibility factors so no further verification is needed. The applicant's declaration of shelter costs is used.

VaCAP Allotment:

The applicant's declaration of monthly shelter expenses will be used to determine the SNAP benefit amount.

- High benefit - **\$140** – shelter expenses total \$500 or more
- Low benefit - **\$66** - shelter expenses total \$500 or less

Eligibility begins the first day of the month an application is received. There is no proration of benefits based on the application date.

VaCAP Certification:

The certification period for cases will be 36 months.

VaCAP Change Reporting:

Households are not required to report changes. Updates through the SDX satisfy SNAP reporting requirements. If a VaCAP participant reports a change that impacts the household's eligibility for VaCAP or benefit amount, the LDSS must act on the change.

The LDSS worker must also evaluate continued VaCAP eligibility when an alert is received for the following changes reported by the SDX monthly updates:

- the participant moves to another Virginia address;
- a change in the mailing address of an Authorized Representative; and
- a change in the name of an Authorized Representative/payee.

Certain SDX monthly case updates will result in the automatic closure of the VaCAP case.

Cases are closed if the SDX reports:

- the participant no longer receives SSI;
- the death of the participant;
- the participant is living in an institution;
- the participant is married;
- a change in the Federal Living Arrangement ;
- the participant has earned income; or
- the participant moved out of state

VaCAP Recertification:

VDSS will generate and mail a combined expiration notice and an application to recertify for VaCAP. VDSS will mail the recertification application to participants in the month before the certification period expires. Participants must complete the application and return it to the local department of social services for processing. Continued eligibility for VaCAP is determined using the same criteria established for the initial application for VaCAP.

There is no interview or additional verifications required.

Eligibility to Opt-Out of VaCAP

A VaCAP participant who wants to opt out of the project must request the case be closed. If the participant subsequently applies for regular SNAP and is found eligible, the participant will not receive a supplement for any month for which VaCAP benefits were received.

FAIR HEARINGS

Fair hearing requests for VaCAP cases are treated the same as all other requests.

QUALITY CONTROL (QC) REVIEWS

VaCAP cases are part of the QC sample for review and are considered in the completion rate. These cases are included in the State's payment error rate calculation. Quality Control identifies VaCAP cases in a state option field for evaluation purposes.

C. RECERTIFICATION

Each household may apply for recertification before the expiration of the certification period in which it is currently participating.

The EW must base eligibility for recertification on circumstances anticipated for the month following the expiration of the current certification period. The same anticipated circumstances must be the basis for the level of benefits for the recertification period.

The local agency must complete the application process if the household meets all the requirements and finishes the necessary processing steps in a timely manner, as defined in this chapter, and approve or deny timely applications for recertification prior to the end of the household's current certification period. The agency must provide eligible households an opportunity to participate by the first of the month following the end of its current certification period.

A household may not receive benefits beyond the end of its certification period unless the household recertifies or unless the agency opts to extend the certification period to match a TANF or Medicaid review period. See Part IV.D for information and limitations on lengthening certification periods.

The joint processing requirements of Part II.G.1 apply to recertification applications. Expedited service processing provisions of Part V apply to recertification applications filed during the month after the previous certification period ends.

The remainder of this chapter describes the processing requirements for recertification applications and the timeframes for each.

1. Notice of Expiration (7 CFR 273.14(b))

The local agency must advise the household that the certification period is about to expire and that a new application is necessary to establish further entitlement. The agency must send the *Notice of Expiration* form to notify households of the end of the certification period. See Part XXIV for the form and instructions.

Except as noted below, households must receive the *Notice of Expiration* no later than the last day of the next to the last month of the current certification period, but not earlier than the first day of the next to the last month of the current certification period. When the agency mails the *Notice of Expiration*, allow two days for delivery in addition to the postmark date. Regardless of when the agency assigns the interview date, the recertification application will be timely if the household files the application by the 15th calendar day of the last month of certification.

TANF or GR households whose applications are jointly processed for SNAP and TANF or GR benefits in accordance with Part II.G.1 need not receive a *Notice of Expiration* if they have already filed an application for the PA re-determination and recertification for SNAP benefits by the time the *Notice of Expiration* would have to be provided.

must also determine if the Food and Nutrition Service (FNS) has certified the facility as a retailer and whether the center has a Point-of-Sale (POS) device in order to use SNAP benefits at the institution.

In order to get SNAP benefits, residents of treatment centers must apply and participate through a designated employee of the center. The household must freely choose to apply for benefits. The resident household should assist in completing the application and should sign the application along with the authorized representative before certification, if possible. Normal SNAP certification notices and procedures apply to households that reside in eligible treatment centers except for the requirement that residents must apply through a representative of the center.

a. Accessing and Using SNAP Benefits

In order to access SNAP benefits, each household or representative must have an EBT card. Eligible household residing in drug or alcohol treatment centers must participate in the Program through an authorized representative. The authorized representative will receive an EBT card to use on behalf of the household. The client may not possess an active EBT card while a resident of the treatment center.

Treatment center representatives must use the SNAP benefits for food prepared by or served to the resident addict/alcoholic. If the treatment center has a POS device, the authorized representative must use each individual household's EBT card to access one-half of the monthly benefit **according to the household's assigned benefit issuance date (1st, 4th, 7th)**. If the treatment center does not have a POS device, the authorized representative must use each resident's EBT card at the grocery store and access up to one-half the benefit amount by the 10th day of each month. The treatment center may access the second half of the benefits on or after the 16th of each month if the resident remains in the center as of the 16th day of the month.

If the household leaves the treatment center before the 16th day of the month, the household is entitled to one-half of the allotment for the month. If the household leaves the treatment center on or after the 16th of the month, the household will not receive any portion of the benefits directly.

b. Responsibilities of the Treatment Center

The treatment center must notify the local agency of changes in the household's income or other household circumstances and upon the departure of the addict or alcoholic from the treatment center. When the resident leaves the facility, the treatment center must provide the resident with the EBT card for the "Primary Cardholder," if the card is available. This is not the card used by the authorized representative. Once the household leaves the treatment center, the center may no longer act as that household's authorized representative.

The center should return the authorized representative's EBT card to the local agency when the resident leaves the facility.

Income received by individuals who are participating in on-the-job training programs funded through the Workforce Innovation and Opportunity Act **is** considered earned income. This provision includes on-the-job training programs funded under the National and Community Services Act, Americorps, the Summer Youth Employment and Training Program, and the Youthbuild Program. This provision, however, does not apply to household members under 19 years of age who are under the parental control of another household member, regardless of school attendance and/or enrollment as discussed in Part XI.F.8. See also Part XI.F.11.d.

4. Payments under Title I of the Domestic Volunteer Service Act of 1973

Payments under Title I of the Domestic Volunteer Service Act of 1973 (VISTA, etc.) count as earned income unless they are excluded from consideration. See Part XI.F.11.c.

5. Payments to Day Care Providers

Payments to day care providers for meals served to children, other than their own, funded by the School Lunch Act will count as earned income to the provider. These payments do not count as reimbursement. See Part XII.A.7 for allowable business costs.

6. Jury Duty Pay (PIRS 88-10)

Jury duty pay is countable earned income unless it meets the infrequent/irregular income or reimbursement policy of Part XI.F.4 or F.6.

Use the following documents or records to verify the earned income of the household. The documents are often available from the applicant.

Pay stubs
Employee's W-2 Form
State or federal income tax return
Sales and expenditure records

Pay envelopes
Wage tax receipts
Self-employment bookkeeping records

Verification from other sources might include:

Employer's wage records
Statement from the employer

VEC Office
State Income Tax Bureau

D. SPECIAL INCOME OF MILITARY PERSONNEL (FNS Policy Memos 81-1, 81-5, and 81-13 and Admin Notice A-24-91)

Many members of the military receive special allowances that count in determining the eligibility and benefit amount of households containing such persons. Military personnel may receive the following allowances:

Efforts to collect amounts issued to sponsored immigrants through the Supplemental Nutrition Assistance Program or other means-tested public benefits must be made within 10 years of the date of the last issuance.

6. Awaiting Verification

If the information necessary to determine the amount of the sponsor's or sponsor's spouse's income and resources attributed to the immigrant, is not received or verified in a timely manner, the sponsored immigrant will be ineligible until all necessary facts are obtained. In addition, if questions arise about whether an immigrant has a sponsor, the date of entry, or the date of the adjustment of status, such questions must be resolved before SNAP eligibility can be established for the immigrant. The eligibility of any remaining household members must be determined. The income and resources of the ineligible immigrant (excluding the attributable income and resources of the alien's sponsor and sponsor's spouse) must be treated in the same manner as a disqualified member as set forth in Parts XI.G and XII.E, and considered available in determining the eligibility and benefit level of the remaining household members.

If the sponsored immigrant refuses to cooperate in providing and/or verifying needed information, other adult members of the immigrant's household will be responsible for providing and/or verifying the information required. If the household refuses to cooperate in this regard, the entire household is ineligible. If the information or verification is subsequently received, the local agency must act on the information as a reported change in household membership as required by the timeliness standards in Part XIV.A.

If the same sponsor is responsible for the entire household, the entire household will be ineligible until the needed sponsor information is provided and/or verified.

D. HOUSEHOLDS WITH A DECREASE IN INCOME DUE TO FAILURE TO COMPLY WITH ANOTHER PROGRAM'S RULES

SNAP benefits must not be increased when a household's benefits from another means-tested, publicly funded program are reduced, terminated, or suspended because of a failure to comply with that program's requirements. Changes that are not related to the penalty imposed by the other program must continue to be reflected in the SNAP benefit amount, including adding household members who may be barred from receiving benefits from other public assistance programs. The public assistance income, as a penalty, must not be counted in the calculation of SNAP benefits if the public assistance case is closed at the household's request, **failing to sign the VIEW Agreement of Personal Responsibility** or for a reason other than noncompliance, regardless of prior case actions that may have been taken due to noncompliance.

1. For federal, state, or local public assistance programs, such as TANF or GR-Unattached Child, failure to comply will be determined to exist after it has been established that policy exemptions and good cause provisions, if appropriate, have not been met. Failure to comply may also be evidenced by a court conviction for a fraud conviction or a finding through the ADH process.

This income will count as long as the local agency did not previously count the income.

Advances on wages count as income in the month received only if the EW can reasonably anticipate the receipt of the income as defined in Part XIII.A.3. Conversely, when an employer withholds wages to repay an advance that previously counted as income in a SNAP determination, the wages withheld will not count as income.

H. TRANSITIONAL BENEFITS FOR FORMER TANF RECIPIENTS

Transitional Benefits allow SNAP benefits to continue in a frozen amount for a brief period while former TANF recipients adjust financially to the loss of the TANF-related income. References to TANF in this chapter also refer to View Transitional Payments. At any time during the Transitional Benefits period, the household may reapply and receive regular SNAP benefits. The Transitional Benefits component does not apply to Diversionary Assistance cases.

1. Transitional Benefits Eligibility

Transitional Benefits will apply to any SNAP case if at least one household member is the Case Name or Payee for a TANF case that closed. When a TANF case closes, the EW must convert the SNAP case to Transitional Benefits unless:

- the SNAP household is ineligible for Transitional Benefits, as listed below;
- the household requests to remain in the regular program; or
- the household requests closure of the SNAP case.

Transitional Benefits will not apply when:

- there is no active case certified to receive SNAP benefits at the time of the action to close the TANF case;
- the TANF case is closed or there is no TANF payment because of noncompliance with TANF Program rules when:
 - there is a sanction or disqualification of the TANF benefits;
 - the household requests closure of a TANF case that is already being sanctioned because of noncompliance;
 - the household preempts the implementation of a sanction or disqualification by requesting closure of the TANF case; or
 - a sanctioned or disqualified case is closed for a reason unrelated to an act of noncompliance but the TANF sanction/disqualification remains in effect.
- **the TANF case is closed for failing to sign the VIEW Agreement of Personal Responsibility.**
- the TANF case is closed because there are no eligible children in the home as a result of a child protective services investigation;

05/18

VOLUME V, PART XV, APPENDIX I, PAGE 2

Localities Whose Residents Are Exempted from the Work Requirement*

**May 2018
April 2019**

**May 2018-
April 2019**

Accomack	Pittsylvania
Alleghany/ Covington	Portsmouth
Bath	Prince Edward
Bland	Prince George
Bristol	Pulaski
Brunswick	Richmond County
Buchanan	Russell
Buckingham	Scott
Carroll	Smyth
Charles City	Surry
Charlotte	Sussex
Craig	Tazewell
Cumberland	Washington
Danville	Westmoreland
Dickenson	Williamsburg
Dinwiddie	Wise
Franklin City	Wythe
Galax	
Grayson	
Greensville/ Emporia	
Halifax	
Hampton	
Henry/ Martinsville	
Highland	
Hopewell	
Lancaster	
Lee	
Lunenburg	
Mecklenburg	
Northampton	
Northumberland	
Norton	
Page	
Patrick	
Petersburg	

*The agency must track the work requirement for all household members except those persons under 18 or over age 50.

TRANSMITTAL #22

- The household cannot be located, unless the claim has been referred to TOP. If the claim has been referred to TOP, the local department of social services may keep the claim active until the claim meets criteria #3, listed above;
- A claim has been discharged through bankruptcy. **The discharge of the debt removes the liability from all liable persons, not just the individual who filed bankruptcy, unless contrary to the court order;**
- A claim has been transferred to another state for collection; or.
- It is no longer cost effective to pursue the claim as the balance is less than \$1 for a participating household or less than \$5 for a household that is not currently participating.

A claim must also be terminated if there is insufficient information or documentation to substantiate that the claim was properly established or to determine the correctness of the balance due. Properly established means that an initial demand letter was mailed or a court ordered repayment.

The local department of social services must document the reason for termination.

Note that a terminated claim may be reinstated if a new collection method or a specific event (such as winnings the lottery) increases the likelihood of further collections.

K. INVALID CLAIMS

A claim found to be invalid through a fair hearing, the ADH process, a court determination, or discovered as erroneously established by the State or local department of social services, must be deleted. If the documentation to support the claim is no longer available and cannot be recreated, the claim must be terminated. Deleted claims are treated as terminated claims.

L. IPV DISQUALIFICATION PENALTIES (7 CFR 273.16(b))

1. IPV Penalties

Individuals found to have committed an IPV, either by a court of appropriate jurisdiction or by an ADH or, who waived their right to an ADH, are ineligible to receive SNAP benefits for:

- a. One year for the first violation;
- b. Two years for the second violation;
- c. Permanently for the third violation; and
- d. Ten years for a determination that fraudulent statements or representations of identity or residency were made to receive benefits in more than one household at the same time. The ten-year penalty does not apply when a household fails to report a move to the agency at a former address.

O. BANKRUPTCY (7 CFR 273.18(j))

Local departments of social services may act on behalf of, and, as USDA, in any bankruptcy proceeding against bankrupt households owing SNAP claims. Local departments of social services possess any rights, priorities, interests, liens or privileges, and must participate in any distributions of assets, to the same extent as USDA. Acting as USDA, local agencies have the power and authority to file objections to discharge, proofs of claims, exceptions to discharge, petitions for revocation of discharge, and any other documents, motions or objections that USDA might have filed. Any amounts collected under this authority must be transmitted to the Virginia Department of Social Services as normal claims payments.

All collection activity on a claim must cease upon receipt of the notice of bankruptcy filing, pending the outcome. If the notice of discharge identifies USDA, FNS, VDSS, or the local department of social services as a creditor whose debt has been discharged, the claim must be terminated and any amounts collected after the date of the bankruptcy filing must be refunded. **The discharge of the debt removes the liability from all liable persons, not just the individual who filed bankruptcy.** If the discharge notice does not identify USDA, FNS, VDSS or the local department of social services as a creditor whose debt has been discharged, collection activity on the claim will resume.

P. SUBMISSION OF PAYMENTS (7 CFR 273.18(l))

Once a month, local departments of social services must submit one consolidated check to cover cash and state tax intercept payments received from all households for the month. The check, payable to the "Treasurer of Virginia" must be sent to:

Virginia Department of Social Services
Division of Finance, **SNAP Collections Unit**
801 East Main Street
Richmond, VA 23219-

The *Monthly Payment Record* (MPR) must be sent with the consolidated check. If no cash or state tax intercept payments are received during the month, the local department of social services must send an e-mail to barbara.mosley@dss.virginia.gov and jewel.lee-gaines@dss.virginia.gov and copy emory.freeman@dss.virginia.gov to acknowledge that no payments were received. The check and MPR, or e-mail must be sent so as to be received by the 15th day of the month following the report month.

Q. DISPUTED CLAIMS

If a fair hearing or a court did not establish the amount of a claim and/or the individual(s) liable for repaying the claim, the household has 90 days from the date of the demand letter to appeal the amount and /or their liability by requesting a fair hearing

The household must also be notified of the following actions relating to claims and has the right to appeal these:

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If a fair hearing or a court did not establish the amount of a claim and/or the individual(s) liable for repaying the claim, the household has 90 days from the date of the demand letter to appeal the amount and /or their liability by requesting a fair hearing

The household must also be notified of the following actions relating to claims and has the right to appeal these:

- After initial notification, whenever the amount of the claim changes;
- Whenever a claim is used to offset a restoration and prior notification of the claim had not been given;
- When multiple overissuances within the last six years total \$125 or more and collection action is now being initiated, and prior notification of the claim had not been given.

If the fair hearing determines that the claim is valid, the local department of social services must re-notify the household of the claim amount. The post-fair hearing notice must inform the household that the claim amount is still due and that repayment is required. A *Repayment Agreement* must be sent with the re-notification. The household cannot request a fair hearing based on this second notice. Delinquency will be determined by the due date of this subsequent notice, not the original demand letter.

R. OTHER MONEY RETURNS

Money is sometimes returned to the agency for reasons other than because of a claim. In these instances, the money is not to be submitted to the State Office as claims payments would be. A check or money order payable to "USDA-FNS-HQ" and a letter explaining the circumstances must be submitted to:

USDA-FNS-HQ
P.O. Box 953807
St. Louis, MO 63195-3809

S. SYSTEM OF RECORD

Virginia Case Management System (VaCMS) is the system of record for claims. This means VaCMS must be used to:

- establish all claims;
- reflect all payments received;
- report terminations of claims; and
- reflect dates for:
 - initial demand letter;
 - follow-up demand letters; and
 - court-ordered restitution.

HOUSEHOLD SIZE	INCOME LIMIT	BENEFIT AMOUNT FULL MONTH	BENEFIT AMOUNT HALF MONTH*
1	\$2,468	\$192	\$ 97
2	3,208	352	176
3	3,685	504	252
4	4,339	640	320
5	4,782	760	380
6	5,341	913	457
7	5,746	1,009	505
8	6,152	1,153	577
Each additional person	+\$406	+\$144	+\$72

* The half-month benefit amount is calculated by dividing the full month amount by two and rounding up to the nearest whole dollar amount.

- d. For eligible households, the worker must complete the Internal Action Form for Disaster Benefits to authorize the issuance of the EBT card. See Appendix I for a copy of the form.

M. DISASTER PROGRAM BENEFIT PERIOD

1. The benefit period for the D-SNAP is not based on a calendar month as it is for the regular program. The benefit period is determined by the disaster benefit period authorized by FNS. The period will be either a half-month (15 days) or a full month (30 days).
2. The full amount of accessible liquid resources must be counted regardless whether the length of the disaster benefit period is a half month or a full month.
3. If the disaster benefit period is a half-month, income over the 15 day period must be counted. If the disaster benefit period is a full month, then income during the 30-day period must be counted. The maximum income limit for the appropriate household size must not exceed the disaster income eligibility limit as shown in the table in Chapter L.

N. VAULT CARD ISSUANCE PROCEDURES

For the D-SNAP, eligible households must receive a new EBT card and EBT account. There must be a new card and account even if households are already known to the EBT system. Procedures for setting up EBT accounts are in Appendix IV of this chapter.

To issue EBT cards in the D-SNAP, the local agency must issue vault cards in the same manner they are issued for regular program operations. The eligibility worker must authorize issuance of a vault card in ADAPT and prepare the Internal Action Form. Refer to the EBT Policy and Procedures Guide.

05/18

VOLUME V, PART XXIV, PAGE i

PART XXIV

FORMS

<u>FORM NUMBER</u>	<u>NAME</u>	<u>PAGES</u>
032-03-0824-33-eng	APPLICATION FOR BENEFITS	1-16
032-03-729A-16-eng	RENEWAL APPLICATION FOR AG, SNAP, AND TANF	17-26
032-03-0823-11-eng	EVALUATION OF ELIGIBILITY	27-31
032-03-823B-03-eng	PARTIAL REVIEWS AND CHANGES	32-34
032-03-0819-12-eng	SNAP - HOTLINE INFORMATION	35-37
032-03-0821-07-eng	KNOW YOUR RIGHTS WHEN APPLYING FOR SNAP BENEFITS	38-39
032-03-0718-07-eng	EXPEDITED SERVICES CHECKLIST	40-41
032-03-0814-10-eng	CHECKLIST OF NEEDED VERIFICATIONS	42-43
032-03-0117-19-eng	NOTICE OF ACTION	44-47
032-03-0018-33-eng	ADVANCE NOTICE OF PROPOSED ACTION	48-51
032-12-0157-20-eng	NOTICE OF EXPIRATION	52-53a
032-03-0051-34-eng	CHANGE REPORT	54-56
032-03-0153-14-eng	ENTITLEMENT TO RESTORATION OF LOST BENEFITS	57-59
032-03-0148-02-eng	REQUEST FOR CONTACT	60-61
032-03-0649-11-eng	INTERIM REPORT FORM – REQUEST FOR ACTION	67-69
032-03-823A-04-eng	PERMANENT VERIFICATION LOG	70-72
032-03-0388-05-eng	FOOD REPLACEMENT REQUEST	73-74
032-03-0387-06-eng	INTERNAL ACTION AND VAULT EBT CARD AUTHORIZATION	75-77
032-02-0072-12-eng	EMPLOYMENT SERVICES PROGRAMS COMMUNICATION FORM	78-80

PART XXIV		FORMS (continued)	
<u>FORM NUMBER</u>	<u>NAME</u>		<u>PAGES</u>
032-03-0174-08-eng	SNAP SANCTION NOTICE FOR NON-COMPLIANCE WITH A WORK REQUIREMENT		81-83
032-03-0721-10-eng	NOTICE OF INTENTIONAL PROGRAM VIOLATION		84-86
032-03-0722-05-eng	WAIVER OF ADMINISTRATIVE DISQUALIFICATION HEARING		87-89
032-03-0725-04-eng	REFERRAL FOR ADMINISTRATIVE DISQUALIFICATION HEARING		90-91
032-03-0724-07-eng	ADVANCE NOTICE OF ADMINISTRATIVE DISQUALIFICATION HEARING		92-94
032-03-0723-09-eng	ADMINISTRATIVE DISQUALIFICATION HEARING DECISION		95-96
032-03-0052-12-eng	NOTICE OF DISQUALIFICATION FOR INTENTIONAL PROGRAM VIOLATION		97-98
032-03-0419-03-eng	MISSED INTERVIEW NOTICE		99-100
032-03-0460-04-eng	NOTICE OF ACTION AND EXPIRATION		101-103
032-03-0658-02-eng	NOTICE OF TRANSFER		111-113
032-03-0227-10-eng	CASE RECORD TRANSFER FORM		114-115
032-03-0440-00-eng	RIGHTS AND RESPONSIBILITIES		116-117
032-03-0572-00-eng	COMPROMISING CLAIMS WORKSHEET		118-119
032-03-729B-14-eng	TANF APPLICATION TO ADD NEW ASSISTANCE MEMBERS		120-122

Commonwealth of Virginia
Department of Social Services
APPLICATION FOR BENEFITS

GENERAL INFORMATION

With this application, you may apply for one or more of the following assistance programs:

- Auxiliary Grants (AG)
- Supplemental Nutrition Assistance Program (SNAP)
- Temporary Assistance for Needy Families (TANF)
- General Relief – Unattached Child (GR)
- Refugee Cash Assistance (RCA)
- TANF Emergency Assistance (TANF EA)

Note that an application for TANF will be treated as an application for SNAP. Be sure to mark **TANF-No SNAP** in the **Household Composition** section if you only want to apply for TANF.

COMPLETING THE APPLICATION

If you need help completing this application, a friend or relative or your eligibility worker can help you. If you are completing this application for someone else, answer each question as if you were that person. If you need to change an answer or make a correction, write the correct information nearby and put your initials and date next to the change. If there are more than 6 people living in your home and you need more space to list everyone, tell the agency you need extra pages. If you have a disability or have difficulty with English, you may receive extra help to make sure you get the assistance or services you are eligible to receive.

COMPLETE AND ACCURATE INFORMATION

You must give complete, accurate, and truthful information. If you do not give needed information, we may not be able to determine your eligibility for assistance. If you knowingly give false, incorrect or incomplete information, or fail to report changes, you could lose your benefits and be arrested, prosecuted, fined and/or imprisoned. If you knowingly give false, incorrect, or incomplete information in order to help someone else receive benefits, you could be arrested and prosecuted for fraud.

FILING THE APPLICATION

You may turn in a partially completed application which contains at least your name, address, and signature (or the signature of your authorized representative), **but you must complete the rest of this application before your eligibility can be determined.** For some programs, you must also be interviewed, but you may turn in your application before your interview. You may turn in your application any time during office hours the same day as you contact your local agency. You have the right to turn in your application even if it looks like you may not be eligible for benefits.

VERIFICATION AND USE OF INFORMATION

Information you give on this application, including Social Security numbers (SSN), may be matched against federal, state, and local records. These records include:

- Virginia Employment Commission (VEC)
- Internal Revenue Service (IRS)
- Social Security Administration (SSA)
- Department of Motor Vehicles (DMV)
- US Citizenship and Immigration Services (USCIS)
- Income and Eligibility Verification System (IEVS)

Any difference between the information you give and these records will be investigated. Information from these records may affect your eligibility and benefit amount. Information may be used to:

- determine the correctness, accuracy, and truthfulness of the application;
- verify your identity and citizenship; verify wages and salary, unemployment benefits, and unearned income, such as Social Security and Supplemental Security Income (SSI) benefits; verify quarters of coverage under Social Security for an alien, or to verify the status of aliens;
- prevent receipt of benefits from more than one social service agency at the same time;
- make required program changes;
- allow disclosure for official examination and to law enforcement officials to assist in apprehending persons fleeing to avoid the law; or
- assist in SNAP claims collection actions.

Your information may also be used or disclosed to study public benefit programs, such as SNAP or TANF.

Information regarding your race and ethnicity is not required and will not affect your eligibility or benefit amount. This information is requested to be sure that program benefits are provided without regard to race, color, or national origin.

SPECIAL INFORMATION FOR SNAP APPLICANTS

You may apply for SNAP benefits by leaving a completed Application for Benefits at the agency or by leaving a partially completed application with at least your name, address, and signature, or by tearing off and leaving the half-sheet on the next page with your name, address, and signature. You must complete the rest of this Application before your eligibility can be determined.

You must also be interviewed in the office or by telephone. You may turn in your application before you are interviewed. This is important because if you are eligible for the month in which you apply, your SNAP amount will be based on the date you actually turn in your application.

NONDISCRIMINATION STATEMENT

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and, in some cases, religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

INSTRUCTIONS FOR COMPLETING THE APPLICATION

1. Do not write in shaded areas. These areas are for agency use only.
2. Complete **SECTION A: APPLICANT INFORMATION**. Complete the grid in **SECTION B: Household Composition** for everyone who lives in your home, even if you are not applying for that person. You may leave questions about citizenship, immigration and Social Security Number blank for anyone for whom you are NOT requesting assistance.
3. Answer the questions in **SECTION C: INCOME** for everyone for whom you are applying. In addition, if you are applying for **TANF**, also provide income information for children age 18 or under, even if you are not applying for that child, and for the stepparent of the children for whom you are applying.
4. Answer the questions in **SECTION D: RESOURCES** for everyone for whom you are applying unless you are applying only for TANF.
5. After completing Sections A through D, answer the questions in the sections indicated below, depending on the type of assistance you are requesting.

TANF	Section E, page 5	TANF Emergency Assistance	Section F, page 6
SNAP	Section G, page 6	Auxiliary Grants	Section H, pages 7-8
8. Read **CHANGE REPORTING AND PENALTIES** on pages 9-10.
9. Read and complete the last page of this application. Be sure to sign and date the application.

EXPEDITED SERVICE FOR SNAP BENEFITS

Your household may qualify for Expedited Service and receive SNAP benefits within 7 days if you are eligible and if your gross monthly income is less than \$150 and liquid resources are \$100 or less; or your monthly shelter bills are higher than your household's gross monthly income plus your liquid resources; or if someone in your household is a migrant or seasonal farm worker with little or no income and resources. **GIVE THE INFORMATION BELOW SO YOUR ELIGIBILITY FOR EXPEDITED SERVICE CAN BE DETERMINED.**

Name: _____

Date of Birth: _____

Address: _____

Social Security Number: _____

Telephone Number: _____

Signature:

Date

Total income received/expected this month before deductions

\$ _____

Total cash, money in checking/savings accounts, CDs, etc.

\$ _____

Total rent or mortgage for this month

\$ _____

Utility expenses for this month

\$ _____

Which utilities do you pay? (check all that apply)

☐ Heat ☐ Lights ☐ Telephone ☐ Electricity for Air Conditioning

☐ Water ☐ Sewer ☐ Garbage ☐ Other

Is anyone in your household a migrant or seasonal farm worker?

☐ YES ☐ NO

COMMONWEALTH OF VIRGINIA VOTER REGISTRATION AGENCY CERTIFICATION

If you are not registered to vote where you live now, would you like to apply to register to vote here today?

(Please check only one)

- ☐ I am already registered to vote at my current address, or I am not eligible to register to vote and do not need an application to register to vote.
- ☐ Yes, I would like to apply to register to vote. (Please fill out the voter registration application form)
- ☐ No, I do not want to register to vote.

If you do not check any box, you will be considered to have decided **not to** register to vote at this time. Applying to register to vote or declining to register to vote will not affect the assistance or services that you will be provided by this agency.

If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will be kept confidential, and it will be used only for voter registration purposes.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private if you desire.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with: Secretary of the Virginia State Board of Elections, Washington Building, 1100 Bank Street, Richmond, VA 23219-3497, Telephone (804) 864-8901.

Applicant Name

Signature

Date

for agency use only

Voter Registration form completed: ☐ Yes ☐ No

Voter Registration form given to applicant for later mailing (at applicant's request)

☐ Yes ☐ No

Agency Staff Signature

Date:

AGENCY USE ONLY		
CASE NAME		
CASE NUMBER		
LOCALITY	SCREENER	DATE
<p style="text-align: center;"><i>EXPEDITED SERVICE DETERMINATION</i></p> <p>Income < \$150 + resources ≤ \$100 <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><i>Income + resources < shelter bills</i> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>For migrant or seasonal farm workers:</p> <p>Resources ≤ \$100 and ≤ \$25 is expected in next 10 days from new income; <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="text-align: center;">OR</p> <p>Resources ≤ \$100 and \$0 income is expected from a terminated source for the rest of this month or next month. <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p style="text-align: center;">EXPEDITE IF <u>YES</u> TO ANY OF THE ABOVE.</p>		

Commonwealth of Virginia
Department of Social Services
APPLICATION FOR BENEFITS

AGENCY USE ONLY		
Case Name	Case Number	Locality
Date Received	Date of Interview:	<input type="checkbox"/> In office <input type="checkbox"/> Telephone
Interviewer	Program (s)	

A. APPLICANT INFORMATION

Your Contact Information

Your Name (last, first, middle initial)

Your Street Address (include apartment number)

City, State, ZIP

Your Mailing Address (if different from your street address)

City, State, ZIP

In what city or county do you live?

Email Address

Primary Telephone Number

Alternate Telephone Number

Directions to your home if there is no street address.

What is the primary language spoken in your household?

- ☐ English ☐ Vietnamese ☐ Laotian ☐ Somali ☐ French ☐ Other (specify):
☐ Spanish ☐ Farsi ☐ Chinese ☐ Kurdish ☐ German
☐ Cambodian ☐ Haitian-Creole ☐ Korean ☐ Arabic ☐ Japanese

Primary Method of Correspondence

If you would like to receive either text or email messages notifying you that some notices about your benefits may be accessed electronically through CommonHelp (www.CommonHelp.Virginia.gov), select one of the choices below. List either a cell telephone number or an email address. Once you choose a preferred electronic method of correspondence, it will be used for all programs on the case for which you have applied. If you do not choose to be notified by text or email, you will receive all written correspondence through the U.S. mail.

If you are completing this application on behalf of another individual as an authorized representative, all correspondence to you will be mailed. The applicant may contact the local department of social services to learn how to change the method of correspondence.

☐ Text ☐ Email Cell Phone Number _____ Email Address _____

- ☐ YES ☐ NO 1. Have you or anyone for whom you are applying ever applied for, or received, or are currently receiving any benefits from a social services agency, including SNAP (Food Stamps), TANF, Medicaid, General Relief, Auxiliary Grant, Foster Care, Adoption Assistance, or Refugee Cash Assistance? If **YES**, enter the information below.

Applicant's Name	Social Security Number	Type of Benefits Received
When	From What County, City, or State	

- ☐ YES ☐ NO 2. Have you or anyone for whom you are applying ever been convicted of making false or misleading statements about your identity or address to receive TANF, SNAP, or Medicaid in two or more states at the same time? If **YES**, give date and place of conviction. _____
- ☐ YES ☐ NO 3. Have you or anyone for whom you are applying ever been disqualified from participating in TANF, SNAP, or Medicaid? If **YES**, give date and place of all disqualifications. _____
- ☐ YES ☐ NO 4. Are you or anyone for whom you are applying in violation of parole or probation or fleeing capture to avoid prosecution or punishment of a felony? If **YES**, explain _____
- ☐ YES ☐ NO 5. Do you or anyone in your home have a felony conviction for drugs after August 22, 1996 for () Use? () Possession? () Distribution of drugs? (check all that apply) If **YES**, who? _____
Did the court assign () Periodic Testing? () Drug Treatment? () Other Action? ☐ YES ☐ NO
If **YES**, have you finished the plan or are you cooperating? ☐ YES ☐ NO

B. HOUSEHOLD COMPOSITION: This section includes information about everyone living in your home, even if you are not applying for that person. You may leave the Social Security Number blank if you are not applying for assistance for the person. List yourself first.

1

Name (last, first, middle initial) _____
Social Security Number: _____
Gender: ☐ Male ☐ Female
Marital Status: ☐ Married ☐ Never Married
☐ Separated ☐ Divorced ☐ Widowed
Highest Grade Completed: _____
School Name if a Student: _____
Are you a veteran or dependent? ☐ Yes ☐ No :
Program(s) Requested:
☐ None ☐ AG ☐ GR ☐ RCA ☐ SNAP
☐ TANF ☐ TANF EA ☐ TANF--No SNAP

Self

Relationship to You _____ **Birth Date** (mm-dd-yyyy) _____
City, State, Country of Birth: _____
Are you a U.S. citizen? ☐ Yes ☐ No
If No, immigration status: _____
US Residency Date: __/__/____
Alien Registration Number: _____
Are you disabled or pregnant? ☐ Yes ☐ No
Are you temporarily living away from home? ☐ Yes ☐ No
Date Left __/__/____ **Expected Return Date** __/__/____
Reason for being away: _____

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Racial Heritage: ☐ White ☐ Black/African American ☐ Asian ☐ Asian & Black/African American ☐ Asian & White
☐ American Indian/Alaskan Native ☐ Black/African American & White ☐ American Indian/Alaskan Native & White
☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaskan Native & Black ☐ Other/Unknown

2

Name (last, first, middle initial) _____
Social Security Number: _____
Gender: ☐ Male ☐ Female
Marital Status: ☐ Married ☐ Never Married
☐ Separated ☐ Divorced ☐ Widowed
Highest Grade Completed: _____
School Name if a Student: _____
Is this person a veteran or dependent? ☐ Yes ☐ No :
Program(s) Requested:
☐ None ☐ AG ☐ GR ☐ RCA ☐ SNAP
☐ TANF ☐ TANF EA ☐ TANF--No SNAP

Relationship to Applicant _____ **Birth Date** (mm-dd-yyyy) _____
City, State, Country of Birth: _____
Is this person a U.S. citizen? ☐ Yes ☐ No
If No, immigration status: _____
US Residency Date: __/__/____
Alien Registration Number: _____
Is this person disabled or pregnant? ☐ Yes ☐ No
Is this person temporarily away from home? ☐ Yes ☐ No
Date Left __/__/____ **Expected Return Date** __/__/____
Reason for being away: _____

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Racial Heritage: ☐ White ☐ Black/African American ☐ Asian ☐ Asian & Black/African American ☐ Asian & White
☐ American Indian/Alaskan Native ☐ Black/African American & White ☐ American Indian/Alaskan Native & White
☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaskan Native & Black ☐ Other/Unknown

3

Name (last, first, middle initial) _____
Social Security Number: _____
Gender: ☐ Male ☐ Female
Marital Status: ☐ Married ☐ Never Married
☐ Separated ☐ Divorced ☐ Widowed
Highest Grade Completed: _____
School Name if a Student: _____
Is this person a veteran or dependent? ☐ Yes ☐ No :
Program(s) Requested:
☐ None ☐ AG ☐ GR ☐ RCA ☐ SNAP
☐ TANF ☐ TANF EA ☐ TANF--No SNAP

Relationship to Applicant _____ **Birth Date** (mm-dd-yyyy) _____
City, State, Country of Birth: _____
Is this person a U.S. citizen? ☐ Yes ☐ No
If No, immigration status: _____
US Residency Date: __/__/____
Alien Registration Number: _____
Is this person disabled or pregnant? ☐ Yes ☐ No
Is this person temporarily away from home? ☐ Yes ☐ No
Date Left __/__/____ **Expected Return Date** __/__/____
Reason for being away: _____

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino
Racial Heritage: ☐ White ☐ Black/African American ☐ Asian ☐ Asian & Black/African American ☐ Asian & White
☐ American Indian/Alaskan Native ☐ Black/African American & White ☐ American Indian/Alaskan Native & White
☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaskan Native & Black ☐ Other/Unknown

HOUSEHOLD COMPOSITION (continued)

If you need more space to list your household members, please ask for another form or write the information on a separate sheet.

4**Name** (last, first, middle initial) _____**Social Security Number:** _____**Gender:** ☐ Male ☐ Female**Marital Status:** ☐ Married ☐ Never Married☐ Separated ☐ Divorced ☐ Widowed**Highest Grade Completed:** _____**School Name if a Student:** _____**Is this person a veteran or dependent?** ☐ Yes ☐ No :**Program(s) Requested:**☐ None ☐ AG ☐ GR ☐ RCA ☐ SNAP
☐ TANF ☐ TANF EA ☐ TANF--No SNAP**Relationship to Applicant** _____**Birth Date** (mm-dd-yyyy) _____**City, State, Country of Birth:** _____**Is this person a U.S. citizen?** ☐ Yes ☐ No

If No, immigration status: _____

US Residency Date: __/__/__**Alien Registration Number:** _____**Is this person disabled or pregnant?** ☐ Yes ☐ No**Is this person temporarily away from home?** ☐ Yes ☐ No**Date Left** __/__/__ **Expected Return Date** __/__/__**Reason for being away:** _____**Providing the following information is voluntary and will not affect eligibility. Please check all that apply.****Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino**Racial Heritage:** ☐ White ☐ Black/African American ☐ Asian ☐ Asian & Black/African American ☐ Asian & White
☐ American Indian/Alaskan Native ☐ Black/African American & White ☐ American Indian/Alaskan Native & White
☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaskan Native & Black ☐ Other/Unknown**5****Name** (last, first, middle initial) _____**Social Security Number:** _____**Gender:** ☐ Male ☐ Female**Marital Status:** ☐ Married ☐ Never Married☐ Separated ☐ Divorced ☐ Widowed**Highest Grade Completed:** _____**School Name if a Student:** _____**Is this person a veteran or dependent?** ☐ Yes ☐ No :**Program(s) Requested:**☐ None ☐ AG ☐ GR ☐ RCA ☐ SNAP
☐ TANF ☐ TANF EA ☐ TANF--No SNAP**Relationship to Applicant** _____**Birth Date** (mm-dd-yyyy) _____**City, State, Country of Birth:** _____**Is this person a U.S. citizen?** ☐ Yes ☐ No

If No, immigration status: _____

US Residency Date: __/__/__**Alien Registration Number:** _____**Is this person disabled or pregnant?** ☐ Yes ☐ No**Is this person temporarily away from home?** ☐ Yes ☐ No**Date Left** __/__/__ **Expected Return Date** __/__/__**Reason for being away:** _____**Providing the following information is voluntary and will not affect eligibility. Please check all that apply.****Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino**Racial Heritage:** ☐ White ☐ Black/African American ☐ Asian ☐ Asian & Black/African American ☐ Asian & White
☐ American Indian/Alaskan Native ☐ Black/African American & White ☐ American Indian/Alaskan Native & White
☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaskan Native & Black ☐ Other/Unknown**6****Name** (last, first, middle initial) _____**Social Security Number:** _____**Gender:** ☐ Male ☐ Female**Marital Status:** ☐ Married ☐ Never Married☐ Separated ☐ Divorced ☐ Widowed**Highest Grade Completed:** _____**School Name if a Student:** _____**Is this person a veteran or dependent?** ☐ Yes ☐ No :**Program(s) Requested:**☐ None ☐ AG ☐ GR ☐ RCA ☐ SNAP
☐ TANF ☐ TANF EA ☐ TANF--No SNAP**Relationship to Applicant** _____**Birth Date** (mm-dd-yyyy) _____**City, State, Country of Birth:** _____**Is this person a U.S. citizen?** ☐ Yes ☐ No

If No, immigration status: _____

US Residency Date: __/__/__**Alien Registration Number:** _____**Is this person disabled or pregnant?** ☐ Yes ☐ No**Is this person temporarily away from home?** ☐ Yes ☐ No**Date Left** __/__/__ **Expected Return Date** __/__/__**Reason for being away:** _____**Providing the following information is voluntary and will not affect eligibility. Please check all that apply.****Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino**Racial Heritage:** ☐ White ☐ Black/African American ☐ Asian ☐ Asian & Black/African American ☐ Asian & White
☐ American Indian/Alaskan Native ☐ Black/African American & White ☐ American Indian/Alaskan Native & White
☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaskan Native & Black ☐ Other/Unknown

C. INCOME

1. Do you or anyone who lives with you receive or expect to receive any of the following types of money from working? Include money from all jobs that you have now or expect to begin: full time, part time, seasonal, temporary, self-employment. Answer Yes or No below and provide the requested information:

Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/> Wages/Salary	<input type="checkbox"/>	<input type="checkbox"/> Earned Sick Pay	<input type="checkbox"/>	<input type="checkbox"/> Domestic Work
<input type="checkbox"/>	<input type="checkbox"/> Contract Income	<input type="checkbox"/>	<input type="checkbox"/> Babysitting/Adult or child care	<input type="checkbox"/>	<input type="checkbox"/> Self-employment
<input type="checkbox"/>	<input type="checkbox"/> Vacation Pay	<input type="checkbox"/>	<input type="checkbox"/> Farming/Fishing	<input type="checkbox"/>	<input type="checkbox"/> Any other money from working
<input type="checkbox"/>	<input type="checkbox"/> Commissions, Bonuses, Tips	<input type="checkbox"/>	<input type="checkbox"/> Odd jobs		

a.

Name (last, first, middle initial)	Employer Name, Address and Telephone Number
Number of Hours Per Week	Rate of Pay
Date Job Started	Next Pay Date (mm-dd-yyyy)
	Pay Schedule <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Twice a Month <input type="checkbox"/> Other

b.

Name (last, first, middle initial)	Employer Name, Address and Telephone Number
Number of Hours Per Week	Rate of Pay
Date Job Started	Next Pay Date (mm-dd-yyyy)
	Pay Schedule <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Biweekly <input type="checkbox"/> Twice a Month <input type="checkbox"/> Other

- ☐ YES ☐ NO 2. Has anyone been fired, laid off, gone on sick or maternity leave, gone on strike, quit a job, or reduced hours worked in the last 60 days? If **YES**, give name and explain: _____

3. Do you or anyone who lives with you (including children) receive or expect to receive any of the following? Answer yes or no below and provide the requested information.

Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/> Social Security	<input type="checkbox"/>	<input type="checkbox"/> Cash gifts or contributions	<input type="checkbox"/>	<input type="checkbox"/> Strike benefits
<input type="checkbox"/>	<input type="checkbox"/> SSI	<input type="checkbox"/>	<input type="checkbox"/> Unemployment benefits	<input type="checkbox"/>	<input type="checkbox"/> Prize winnings
<input type="checkbox"/>	<input type="checkbox"/> VA benefits	<input type="checkbox"/>	<input type="checkbox"/> Room/board income	<input type="checkbox"/>	<input type="checkbox"/> All food, clothing, utilities, or rent
<input type="checkbox"/>	<input type="checkbox"/> Child support, alimony	<input type="checkbox"/>	<input type="checkbox"/> Black Lung benefits	<input type="checkbox"/>	<input type="checkbox"/> Other retirement
<input type="checkbox"/>	<input type="checkbox"/> Public Assistance (TANF, GR etc)	<input type="checkbox"/>	<input type="checkbox"/> Worker compensation	<input type="checkbox"/>	<input type="checkbox"/> Interest, dividends
<input type="checkbox"/>	<input type="checkbox"/> Military Allotment	<input type="checkbox"/>	<input type="checkbox"/> Rental Income	<input type="checkbox"/>	<input type="checkbox"/> Insurance settlement
<input type="checkbox"/>	<input type="checkbox"/> Training allowances (WIA, etc.)	<input type="checkbox"/>	<input type="checkbox"/> Inheritance	<input type="checkbox"/>	<input type="checkbox"/> Refugee Matching Grant
<input type="checkbox"/>	<input type="checkbox"/> Loans	<input type="checkbox"/>	<input type="checkbox"/> Railroad retirement	<input type="checkbox"/>	<input type="checkbox"/> Any other type of money

a.	\$		
Name of Person	Amount	Type of Money or Help	How Often Received?
b.	\$		
Name of Person	Amount	Type of Money or Help	How Often Received?
c.	\$		
Name of Person	Amount	Type of Money or Help	How Often Received?

- ☐ YES ☐ NO 4. Does anyone besides the people on your case pay directly for you, help you pay, or lend you money to pay rent, utilities, medical bills or any other bills? OR does anyone totally supply food, shelter or clothing for you or someone else on a regular basis? If **YES**, give name, amount, and explain: _____

- ☐ YES ☐ NO 5. Does anyone have a day care expense for a child, an elderly person, or an adult with a disability? If **YES**, give name, amount and explain: _____

- ☐ YES ☐ NO 6. Does anyone pay legally obligated child support to someone who is not in the household? If **YES**, give name of person paying, person supported, and amount: _____

D. RESOURCES

You do not have to complete this section if you are only applying for TANF. Otherwise, answer for everyone for whom you are applying. Include any resources anyone owns, or that are jointly owned with someone else, even if that person does not live with you. List the names of all joint owners.

1. Do you or anyone who lives with you have any of the following resources or assets?

Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/> Cash \$_____	<input type="checkbox"/>	<input type="checkbox"/> Checking, Savings	<input type="checkbox"/>	<input type="checkbox"/> Credit Union
<input type="checkbox"/>	<input type="checkbox"/> 401K, 403B, etc	<input type="checkbox"/>	<input type="checkbox"/> Promissory notes	<input type="checkbox"/>	<input type="checkbox"/> Money Market Funds
<input type="checkbox"/>	<input type="checkbox"/> Individual Retirement Account (IRA)	<input type="checkbox"/>	<input type="checkbox"/> Christmas Club	<input type="checkbox"/>	<input type="checkbox"/> Deeds of Trust
<input type="checkbox"/>	<input type="checkbox"/> Deferred Compensation Plan	<input type="checkbox"/>	<input type="checkbox"/> Uniform Gift to Minor Account	<input type="checkbox"/>	<input type="checkbox"/> Retirement accounts
<input type="checkbox"/>	<input type="checkbox"/> Keogh Plan	<input type="checkbox"/>	<input type="checkbox"/> Certificate of Deposit (CD)	<input type="checkbox"/>	<input type="checkbox"/> Trust funds
<input type="checkbox"/>	<input type="checkbox"/> Stocks or bonds	<input type="checkbox"/>	<input type="checkbox"/> Pension plans	<input type="checkbox"/>	<input type="checkbox"/> Other

— If **Yes to any of the above**, please provide the following information:

a.

Owner Name (last, first, middle initial)		Co-Owner Name (last, first, middle initial)	
Name of Bank or Institution	Account Type	Account Number	\$ Balance
Address of Bank or Institution			

b.

Owner Name (last, first, middle initial)		Co-Owner Name (last, first, middle initial)	
Name of Bank or Institution	Account Type	Account Number	\$ Balance
Address of Bank or Institution			

☐ YES ☐ NO 2. Has anyone sold, transferred or given away any resources in the last 3 months (for SNAP) or in the last 3 years (for Auxiliary Grants)? If YES, explain:

E. TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) (ASK FOR AN EXTRA PAGE IF YOU NEED MORE SPACE)

1. CHILD/PARENT INFORMATION	2. IMMUNIZATION
List each child for whom you are applying. Then, list the names of both parents. You must identify both parents in order to receive TANF. If you intentionally misidentify a parent, you shall be prosecuted	(Answer only if applying for TANF.) Has the child received ALL of the immunizations required according to the child's age? Check (✓) Yes Or No Or Unknown
Child's Name	Yes () No () Unknown ()
Mother	
Father	
Child's Name	Yes () No () Unknown ()
Mother	
Father	
Child's Name	Yes () No () Unknown ()
Mother	
Father	
Child's Name	Yes () No () Unknown ()
Mother	
Father	

F. TANF EMERGENCY ASSISTANCE

☐ YES ☐ NO 1. Have you or your family experienced a natural disaster or fire in the past 30 days? If **YES**, give date and explain.

☐ YES ☐ NO 2. As a result of the natural disaster or fire, does anyone have emergency needs, such as replacement of clothing, or the repair or replacement of household equipment and supplies which were destroyed?

Description and cause of emergency

G. SNAP BENEFITS (formerly Food Stamps)

1. List the name of the person who is the head of your household: _____.
2. An authorized representative may apply for SNAP benefits on your behalf, receive and use your SNAP benefits on your behalf, or receive copies of your program notices. If you want to name an authorized representative, please give the information below about the representative and what you want the representative to do on your behalf. Note that you may have only one representative who can access your benefits.

Name, Address and Telephone Number of the Authorized Representative	Check (✓) each duty authorized for that person
	<input type="checkbox"/> Apply for SNAP benefits <input type="checkbox"/> Receive correspondence <input type="checkbox"/> Access or use SNAP benefits
	<input type="checkbox"/> Apply for SNAP benefits <input type="checkbox"/> Receive correspondence <input type="checkbox"/> Access or use SNAP benefits

☐ YES ☐ NO 3. Is anyone living in your home NOT included in your SNAP application? If **YES**, do you and everyone for whom you are applying usually purchase and prepare meals apart from these people? Or, do you intend to do so if your application for SNAP benefits is approved? Check (✓) ☐ YES ☐ NO

☐ YES ☐ NO 4. Is anyone living in your home renting a room from you (a roomer) or being provided a room and food (a boarder)? If **YES**, list names: _____

☐ YES ☐ NO 5. Is anyone age 60 or older **or** approved to receive Medicaid because of a disability **or** receiving any type of disability payment? If **YES**, list all current medical expenses for these people.

Household Member with Medical Expense	Type of Expense	Amount	Name of Doctor, Hospital, Pharmacy

☐ YES ☐ NO 6. Do you have any of the following shelter expenses? If **YES**, list your current expenses. Check (✓) here ☐ if these expenses are for a house you do not live in.

Expense	Amount Billed	How Often Billed?	Who is Responsible for the Bill?
Rent/Mortgage			
Taxes/ Insurance			
Electricity			
Gas/Oil/Kerosene/Coal/Wood			
Water/Sewage/Garbage			
Telephone			
Installation			

6a How do you heat your home? _____

☐ YES ☐ NO 6b Do you have air conditioning in your home?

☐ YES ☐ NO 6c Did you receive energy/fuel assistance during this past year while living in your current home?

☐ YES ☐ NO 6d Are you staying temporarily in someone else's home, an emergency shelter, welfare hotel, other halfway house, or a place not usually used for sleeping? If **YES**, how much does it cost to stay there during the month?

If you are staying temporarily in someone else's home, when did you move there? _____

6H. AUXILIARY GRANTS (AG)

☐ YES ☐ NO 1 Do you live in an Assisted Living Facility, an Adult Foster Care Home, a Nursing Facility, or other institution? If **YES**, Date Applicant Entered _____

City/County and State where you lived before entering the institution _____.

If outside Virginia, was placement made by a government agency? ☐ YES ☐ NO

☐ YES ☐ NO 2 Do you have a spouse who does not live in the home? If YES, enter the Spouse's Name and address

☐ YES ☐ NO 3. Have you lived in Virginia for the past 90 days?

☐ YES ☐ NO 4. Do you owe or did you pay any bills you had in the month of entry into an assisted living facility or adult foster care?

☐ YES ☐ NO 5. Do you have any unpaid medical bills for the three months before the application month?

Description of Bills	Dates of Bills	Dates Bills Paid

☐ YES ☐ NO 6. Do you own any household goods or personal effects worth more than \$500? If YES, list the items and their value here. _____

☐ YES ☐ NO 7. Do you have any burial plots, burial arrangement or trust funds for burial?

Owner(s)	Number of Plots, Type of Arrangement:	Where	Value \$ Amount Owed \$	Date Acquired

☐ YES ☐ NO 8. Does anyone own any personal property, such as campers/trailers, non-motorized boats, utility trailers, tools, equipment, supplies, or livestock?

Owner(s)	Type	Is this property used in your business or trade, including farming? YES () NO ()	Value	Amount Owed	Date Acquired

☐ YES ☐ NO 9. Does anyone own any real property, including life estates, inherited property, land, buildings, or mobile homes? If YES, do you live there? Check (✓): ☐ YES ☐ NO

Owner(s)	Type	YES () NO () Currently rented? YES () NO () Income-producing? YES () NO () Currently for sale?	Value \$	Amount Owed \$	Date Acquired

☐ YES ☐ NO 10. Does anyone own vehicles, such as cars, trucks, vans, motorboats, motor homes, recreational vehicles, or motorcycles/mopeds?

Owner(s)	Type, Make, Model, Year	Currently Licensed? <input type="checkbox"/> YES <input type="checkbox"/> NO	Vehicle ID# License # # #	Value Amount Owed \$ \$	How Used	Date Acquired

☐ YES ☐ NO 11. Do you own any household goods or personal effects worth more than \$500, such as silver, fine china, furs, artwork, jewelry, or other items held for their value or as an investment?

Description and Value of Items

☐ YES ☐ NO 12. Does anyone have any life insurance? If YES, provide information about each policy. List each policy separately. Attach a separate sheet if necessary.

Owner	Person Insured	Type of Insurance <input type="checkbox"/> Whole Life <input type="checkbox"/> Term	Face Value \$	Cash Value \$
Company Name	Policy Number			
Owner	Person Insured	Type of Insurance <input type="checkbox"/> Whole Life <input type="checkbox"/> Term	Face Value \$	Cash Value \$
Company Name	Policy Number			
Owner	Person Insured	Type of Insurance <input type="checkbox"/> Whole Life <input type="checkbox"/> Term	Face Value \$	Cash Value \$
Company Name	Policy Number			

H. AUXILIARY GRANTS (AG) continued

An application for AG is also an application for Medicaid. The following questions will help determine Medicaid eligibility through the Department of Social Services or possible eligibility for Advanced Premium Tax Credits (APTC) for private health insurance through the Federal Marketplace (Healthcare.gov).

☐ YES ☐ NO 13. Does anyone have health insurance? If Yes, complete the following:

Policy Holder:	Person(s) Insured:
Company Name, Address, Phone:	
Coverage Type:	Begin Date: / / End Date: : / /
ID Number:	Premium Amount: \$

☐ YES ☐ NO 14. Does anyone have Medicare?

Person Insured	Claim Number	Coverage
		<input type="checkbox"/> Part A <input type="checkbox"/> Part B
		<input type="checkbox"/> Part A <input type="checkbox"/> Part B

15. List the names of everyone expected to be included on the same tax return as you for this year, whether or not they live in the same home as you. For anyone in the home that does not file taxes and does not expect to be on anyone else's tax return, list those names under "Non-filer(s)".

Tax Filer:	
Joint Taxpayer:	
Tax Dependent(s):	
Non-filer(s):	

CHANGE REPORTING, RESPONSIBILITIES, AND PENALTIES
(READ THIS SECTION CAREFULLY BEFORE SIGNING THIS APPLICATION)

REPORTING CHANGES

You must report changes that occur. What you need to report and when you need to report it varies by each program as listed below or on the next page for SNAP.

TANF/Refugee Cash Assistance: Report within 10 days, but no later than the 10th day of the month after a change occurs. Report these changes:

- Your household income goes over 130% of the Federal poverty level. See the Change Report or the Notice of Action for the amount or visit www.dss.virginia.gov.
- Your address changes.
- An eligible individual leaves or enters the home.
- Changes that may affect your participation in VIEW such as, changes in income, employment, education, training, transportation, and child care.

General Relief-Unattached Child: Report the day the change occurs or the first day that the agency is open after the change occurs. Report these changes:

- Your address changes.
- The amount of your monthly income changes.
- There are other changes that may affect eligibility.

Auxiliary Grants: Report changes within 10 days. Report these changes:

- Your address changes.
- The amount of your monthly income changes.
- There are changes in your resources, including transferring assets/property or in any motor vehicles owned.

PENALTIES FOR TANF AND REFUGEE CASH ASSISTANCE (RCA) VIOLATIONS

You must not knowingly give false information, hide information, or fail to report changes on time in order to receive TANF or RCA, or to receive supportive or transitional services such as child care or assistance with transportation.

If you are found guilty of intentionally breaking these rules, you will be ineligible to receive TANF or RCA for yourself for 6 months (1st violation), 12 months (2nd violation), or permanently (3rd violation). In addition, you may be prosecuted under Federal or State law.

Anyone convicted of misrepresenting his or her residence to get TANF, Medicaid, SNAP benefits or SSI in two or more states is ineligible for TANF for 10 years.

Anyone convicted of a drug-related felony for actions that occurred after August 22, 1996, could be barred permanently.

SNAP CHANGE REPORTING, RESPONSIBILITIES, AND PENALTIES
(READ THIS SECTION CAREFULLY BEFORE SIGNING THIS APPLICATION)

You must report changes that occur for SNAP but, what you must report is tied to how long you are determined eligible for benefits, the certification period. You must report changes that occur during the certification period within 10 days, but no later than the 10th day of the month after the change occurs.

Changes that need to be reported during the certification period for SNAP depend on the length of the certification period. "Simplified Reporting" applies to households that are eligible for SNAP benefits for five (5) months or longer. "Change Reporting" applies to households that are eligible for one (1) month to four (4) months. Changes that need to be reported for each category are listed below.

INTERIM REPORT FILING

In addition to reporting changes when they occur during the SNAP certification period, Simplified Reporting households may be required to submit an Interim Report in the sixth or twelfth month. The Interim Report is used to determine the amount of SNAP benefits households will receive for the second half of the certification period. The Interim Report provides a snapshot of household circumstances that were presented at the time of application. We will ask for proof of income changes and changes in legal obligations to pay child support. If households fail to return the completed Interim Report by the fifth of the month, SNAP benefits for the seventh or thirteenth month may be delayed or closed. Assistance for filing the Interim Report is available by calling the telephone number printed on the form.

REPORTING REQUIREMENTS – SIMPLIFIED REPORTING HOUSEHOLDS

Certified five months or longer, households must report::

- All the income for your household, before taxes, goes over 130% of the Federal poverty level. See the Change Report or the Notice of Action for the amount or visit www.dss.virginia.gov.
- The number of work hours in a week goes under 20 for anyone who is 18-49 if there are no children in your SNAP household.

REPORTING REQUIREMENTS – CHANGE REPORTING HOUSEHOLDS

Certified four months or less), households must report:

- There is a change in the number of people in your household;
- Your address changes, including shelter expenses that change resulting from the move;
- The obligation to pay child support changes or the amount paid to someone outside the household changes;
- Your liquid resources, such as bank accounts, cash, bonds, etc. are \$2,250 or \$3,250* or more;
- The number of work hours goes under 20 per week for persons who are between the ages of 18-50 if there are no children in the home; or
- There are changes in income:
 - There are unearned income changes of more than \$50 for income sources such as Social Security, SSI, pensions, etc.;
 - There are earned income changes of more than \$100 for money received from working;
 - You start or stop a job: or
 - Your job switches from full-time to part-time or part-time to full-time.

SNAP RESPONSIBILITIES AND PENALTIES FOR VIOLATIONS

You must not:

- give false information or hide information to get SNAP benefits;
- trade or sell EBT cards or attempt to trade or sell EBT cards;
- use SNAP benefits to buy non-food items, such as alcohol, tobacco or paper products;
- use someone else's EBT card for your household.
- buy an item and discard the contents in order to get the return deposit for the container;
- resell a purchased product for cash or exchange a purchased product for consideration other than eligible food; or
- purchase food on credit.

If you intentionally break any of these rules, you could be barred from getting SNAP benefits for 12 months (1st violation), 24 months (2nd violation), or permanently (3rd violation); fined up to \$250,000, imprisoned up to 20 years, or both; and suspended for an additional 18 months and further prosecuted under other Federal and State laws.

If you intentionally give false information or hide information about identity or residence to get SNAP benefits in more than one locality at the same time, you could be barred for 10 years.

If you are convicted in court of trading or selling SNAP benefits of \$500.00 or more, you could be barred permanently.

If you are convicted in court of trading SNAP benefits for a controlled substance, you could be barred for 24 months for the 1st violation, permanently for the 2nd violation.

If you are convicted in court of trading SNAP benefits for firearms, ammunition, or explosives, you could be barred permanently for the first violation.

BY MY SIGNATURE BELOW, I DECLARE:

- I read the information at the beginning of this application and the Change Reporting and Penalties section of this application.
- I understand that if I refuse to cooperate with any review of my eligibility, including a review by Quality Assurance, my benefits may be denied until I cooperate.
- I understand that if my application is for SNAP benefits, failure to report or verify any of my expenses will be seen as a statement by my household that I do not want to receive a deduction for these expenses.
- I have given true and correct information on this application to the best of my knowledge and belief. I understand that if I give false information, withhold information, or fail to report a change promptly or on purpose, I may be breaking the law and could be prosecuted for perjury, larceny, and/or welfare fraud. I understand that if I help someone complete this form in order to get benefits he or she is not entitled to receive, I may be breaking the law and could be prosecuted.
- As a condition of receiving TANF, I agree to assign all of my rights to financial support paid to me and to anyone for whom I am receive TANF. After my application for TANF is approved, I agree to give any support payments I receive to the Division of Child Support Enforcement.
- I authorize the Department of Social Services and refugee service contractors to obtain any verification necessary to both determine and review financial assistance eligibility. This authorization is valid for one year from the date of my signature below. I understand that this time limit does not apply as long as my medical assistance case is open or to investigations regarding possible fraud.
- As an applicant for Auxiliary Grants, I understand that my application will be evaluated for Medicaid. I agree to assign my rights to medical support and other third-party payments to the Department of Medical Assistance Services (DMAS). I also agree to assign the rights of anyone for whom I am applying for Auxiliary Grants to medical support and other third-party payments to DMAS. If I do not agree to assign these rights, I will be ineligible for Medicaid.
- I understand that, to the extent allowed by federal law, information about this application may be shared with agencies under the Secretary of Health and Human Resources for Virginia. Informatin about applicants for and recipients of services may be shared to: 1) streamline administrative processes and reduce administrative burdens on the agencies; 2) reduce paperwork and administrative burdens on appllicants and recipients; and 3) improve access to and the quality of services provided by the agencies.
- I understand that different state agencies provide different services and benefits. Each agency must have specific information to determine eligibility services and benefits.
☐ **I allow** ☐ **I do not allow** the Department of Social Services to disclose certain information about me to other state agencies, including information in electronic databases, for the purpose of determining my eligibility for benefits/services provided by that agency. This disclosure will make it easier for agencies to work together efficiently to provide or coordinate services and benefits. Agencies include, but are not limited to, the Department of Health, and the Department for Aging and Rehabilitative Services. I can withdraw this authorization at any time by notifying my eligibility worker.

I filled in this application myself ☐ **YES** ☐ **NO**. If **NO**, it was read back to me when completed. ☐ **YES** ☐ **NO**.

Applicant's Signature or Mark

Date

Witness To Mark or Interpreter

Date

Signature of the Spouse or Authorized Representative

Date

Complete the section below if this application was completed for the applicant by someone else.

Name of Person Completing Application

Date

Address

Primary Telephone

Alternate Telephone

Relationship to Applicant

APPLICATION FOR BENEFITS

FORM NUMBER - 032-03-0824

PURPOSE OF FORM - To record a household's request for assistance and to provide information about the current situation needed to determine eligibility.

NUMBER OF COPIES - One.

DISPOSITION OF FORM - The application is to be completed by or on behalf of the applying household. The completed application may be mailed to the agency or completed at the agency prior to or during an interview. The completed application is to be filed in the eligibility case record. The application must be retained for a minimum of three years.

The application may be used to apply for benefits of other programs if assistance is requested within three months of the original filing date. The date of the application in this instance is the date of the secondary request.

INSTRUCTIONS FOR PREPARATION OF FORM - General instructions appear of the form for completion.

If changes need to be made after the application is completed, the applicant should write the revised information near the original entry. The applicant must initial and date the changes. Except for agency-use sections, eligibility workers may not add to or write on a completed application.

**RENEWAL APPLICATION FOR AUXILIARY GRANT (AG), SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM (SNAP),
AND TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)**

This is an application to renew your eligibility for benefits. You may bring this application to the local Department of Social Services office or mail it to the local Department of Social Services office. You may also apply online for renewal for SNAP or TANF at <https://commonhelp.virginia.gov/access/>.

A. HOUSEHOLD INFORMATION**1. Your Contact Information**

Your Name (last, first, middle initial) _____

Your Street Address (include apartment number) _____

City, State, ZIP _____

Your Mailing Address (if different from your street address) _____

City, State, ZIP _____

In what city or county do you live? _____

E-mail Address _____

Primary Telephone Number _____

Alternate Telephone Number _____

Primary Method of Correspondence

If you would like to receive either text or email messages notifying you that some notices about your benefits may be accessed electronically through CommonHelp (www.CommonHelp.Virginia.gov), select one of the choices below. List either a cell telephone number or an email address. Once you choose a preferred electronic method of correspondence, it will be used for all programs on the case for which you have applied. If you do not choose to be notified by text or email, you will receive all written correspondence through the U.S. mail.

If you are completing this application on behalf of another individual as an authorized representative, all correspondence to you will be mailed. The applicant may contact the local department of social services to learn how to change the method of correspondence.

☐ **Text** ☐ **Email Cell Phone Number** _____ **Email Address** _____

2. Household Composition: This section includes information about everyone living in your home, even if you are not applying for that person. You may leave the Social Security Number blank if you are not applying for assistance for the person.

1

Name (last, first, middle initial) _____

Social Security Number: _____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Never Married

☐ Separated ☐ Divorced ☐ Widowed

Highest Grade Completed: _____

School Name if a Student: _____

Are you a veteran or dependent? ☐ Yes ☐ No :

Program(s) Requested:

☐ None ☐ AG ☐ SNAP ☐ TANF

Self

Relationship to You _____

Birth Date (mm-dd-yyyy) _____

City, State, Country of Birth: _____

Are you a U.S. citizen? ☐ Yes ☐ No

If No, immigration status: _____

US Residency Date: ____/____/____

Alien Registration Number: _____

Are you disabled or pregnant? ☐ Yes ☐ No

Are you temporarily living away from home? ☐ Yes ☐ No

Date Left ____/____/____ **Expected Return Date** ____/____/____

Reason for being away: _____

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Racial Heritage: ☐ White ☐ Black/African American ☐ Asian ☐ Asian & Black/African American ☐ Asian & White

☐ American Indian/Alaskan Native ☐ Black/African American & White ☐ American Indian/Alaskan Native & White

☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaskan Native & Black ☐ Other/Unknown

Household Composition (continued)

If you need more space to list your household members, please ask for another form or write the information on a separate sheet.

2**Name** (last, first, middle initial) _____**Social Security Number:** _____**Gender:** ☐ Male ☐ Female**Marital Status:** ☐ Married ☐ Never Married☐ Separated ☐ Divorced ☐ Widowed**Highest Grade Completed:** _____**School Name if a Student:** _____**Is this person a veteran or dependent?** ☐ Yes ☐ No :**Program(s) Requested:**☐ None ☐ AG ☐ SNAP ☐ TANF**Relationship to Applicant** _____**Birth Date** (mm-dd-yyyy) _____**City, State, Country of Birth:** _____**Is this person a U.S. citizen?** ☐ Yes ☐ No

If No, immigration status: _____

US Residency Date: ____/____/____**Alien Registration Number:** _____**Is this person disabled or pregnant?** ☐ Yes ☐ No**Is this person temporarily away from home?** ☐ Yes ☐ No**Date Left** ____/____/____ **Expected Return Date** ____/____/____**Reason for being away:** _____**Providing the following information is voluntary and will not affect eligibility. Please check all that apply.****Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino**Racial Heritage:** ☐ White ☐ Black/African American ☐ Asian ☐ Asian & Black/African American ☐ Asian & White☐ American Indian/Alaskan Native ☐ Black/African American & White ☐ American Indian/Alaskan Native & White☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaskan Native & Black ☐ Other/Unknown**3****Name** (last, first, middle initial) _____**Social Security Number:** _____**Gender:** ☐ Male ☐ Female**Marital Status:** ☐ Married ☐ Never Married☐ Separated ☐ Divorced ☐ Widowed**Highest Grade Completed:** _____**School Name if a Student:** _____**Is this person a veteran or dependent?** ☐ Yes ☐ No :**Program(s) Requested:**☐ None ☐ AG ☐ SNAP ☐ TANF**Relationship to Applicant** _____**Birth Date** (mm-dd-yyyy) _____**City, State, Country of Birth:** _____**Is this person a U.S. citizen?** ☐ Yes ☐ No

If No, immigration status: _____

US Residency Date: ____/____/____**Alien Registration Number:** _____**Is this person disabled or pregnant?** ☐ Yes ☐ No**Is this person temporarily away from home?** ☐ Yes ☐ No**Date Left** ____/____/____ **Expected Return Date** ____/____/____**Reason for being away:** _____**Providing the following information is voluntary and will not affect eligibility. Please check all that apply.****Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino**Racial Heritage:** ☐ White ☐ Black/African American ☐ Asian ☐ Asian & Black/African American ☐ Asian & White☐ American Indian/Alaskan Native ☐ Black/African American & White ☐ American Indian/Alaskan Native & White☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaskan Native & Black ☐ Other/Unknown**4****Name** (last, first, middle initial) _____**Social Security Number:** _____**Gender:** ☐ Male ☐ Female**Marital Status:** ☐ Married ☐ Never Married☐ Separated ☐ Divorced ☐ Widowed**Highest Grade Completed:** _____**School Name if a Student:** _____**Is this person a veteran or dependent?** ☐ Yes ☐ No :**Program(s) Requested:**☐ None ☐ AG ☐ SNAP ☐ TANF**Relationship to Applicant** _____**Birth Date** (mm-dd-yyyy) _____**City, State, Country of Birth:** _____**Is this person a U.S. citizen?** ☐ Yes ☐ No

If No, immigration status: _____

US Residency Date: ____/____/____**Alien Registration Number:** _____**Is this person disabled or pregnant?** ☐ Yes ☐ No**Is this person temporarily away from home?** ☐ Yes ☐ No**Date Left** ____/____/____ **Expected Return Date** ____/____/____**Reason for being away:** _____**Providing the following information is voluntary and will not affect eligibility. Please check all that apply.****Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino**Racial Heritage:** ☐ White ☐ Black/African American ☐ Asian ☐ Asian & Black/African American ☐ Asian & White☐ American Indian/Alaskan Native ☐ Black/African American & White ☐ American Indian/Alaskan Native & White☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaskan Native & Black ☐ Other/Unknown

Household Composition (continued)

5

Name (last, first, middle initial) _____

Social Security Number: _____

Gender: ☐ Male ☐ FemaleMarital Status: ☐ Married ☐ Never Married☐ Separated ☐ Divorced ☐ Widowed

Highest Grade Completed: _____

School Name if a Student: _____

Is this person a veteran or dependent? ☐ Yes ☐ No :

Program(s) Requested:

☐ None ☐ AG ☐ SNAP ☐ TANF

Relationship to Applicant _____

Birth Date (mm-dd-yyyy) _____

City, State, Country of Birth: _____

Is this person a U.S. citizen? ☐ Yes ☐ No

If No, immigration status: _____

US Residency Date: __/__/__

Alien Registration Number: _____

Is this person disabled or pregnant? ☐ Yes ☐ NoIs this person temporarily away from home? ☐ Yes ☐ No

Date Left __/__/__ Expected Return Date __/__/__

Reason for being away: _____

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/LatinoRacial Heritage: ☐ White ☐ Black/African American ☐ Asian ☐ Asian & Black/African American ☐ Asian & White
☐ American Indian/Alaskan Native ☐ Black/African American & White ☐ American Indian/Alaskan Native & White
☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaskan Native & Black ☐ Other/Unknown

6

Name (last, first, middle initial) _____

Social Security Number: _____

Gender: ☐ Male ☐ FemaleMarital Status: ☐ Married ☐ Never Married☐ Separated ☐ Divorced ☐ Widowed

Highest Grade Completed: _____

School Name if a Student: _____

Is this person a veteran or dependent? ☐ Yes ☐ No :

Program(s) Requested:

☐ None ☐ AG ☐ SNAP ☐ TANF

Relationship to Applicant _____

Birth Date (mm-dd-yyyy) _____

City, State, Country of Birth: _____

Is this person a U.S. citizen? ☐ Yes ☐ No

If No, immigration status: _____

US Residency Date: __/__/__

Alien Registration Number: _____

Is this person disabled or pregnant? ☐ Yes ☐ NoIs this person temporarily away from home? ☐ Yes ☐ No

Date Left __/__/__ Expected Return Date __/__/__

Reason for being away: _____

Providing the following information is voluntary and will not affect eligibility. Please check all that apply.Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/LatinoRacial Heritage: ☐ White ☐ Black/African American ☐ Asian ☐ Asian & Black/African American ☐ Asian & White
☐ American Indian/Alaskan Native ☐ Black/African American & White ☐ American Indian/Alaskan Native & White
☐ Native Hawaiian/Other Pacific Islander ☐ American Indian/Alaskan Native & Black ☐ Other/Unknown

- ☐ YES ☐ NO 3. Is anyone in violation of parole or probation or fleeing capture to avoid prosecution or punishment of a felony? If YES, explain: _____
- ☐ YES ☐ NO 4. Has anyone been convicted of a felony that occurred after August 22, 1996, for possession, use, or distribution of drugs? If YES, explain: _____
- ☐ YES ☐ NO 5. Have any of your children received any immunizations since approval of your original application or since your most recent review? If YES, explain: _____
- ☐ YES ☐ NO 6. Have you or anyone for whom you are applying ever been disqualified from receiving TANF (AFDC) or SNAP benefits? If YES, explain: _____

RESOURCES

You do not have to complete this section if you are only renewing for TANF. Otherwise, answer for everyone for whom you are applying. Include any resources anyone owns, or that are jointly owned with someone else, even if that person does not live with you. List the names of all joint owners.

1. Do you or anyone who lives with you have any of the following resources or assets? .

Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/> Cash \$_____	<input type="checkbox"/>	<input type="checkbox"/> Checking, Savings	<input type="checkbox"/>	<input type="checkbox"/> Credit Union
<input type="checkbox"/>	<input type="checkbox"/> 401K, 403B, etc.	<input type="checkbox"/>	<input type="checkbox"/> Promissory notes	<input type="checkbox"/>	<input type="checkbox"/> Money Market Funds
<input type="checkbox"/>	<input type="checkbox"/> Individual Retirement Account (IRA)	<input type="checkbox"/>	<input type="checkbox"/> Christmas Club	<input type="checkbox"/>	<input type="checkbox"/> Deeds of Trust
<input type="checkbox"/>	<input type="checkbox"/> Deferred Compensation Plan	<input type="checkbox"/>	<input type="checkbox"/> Uniform Gift to Minor Account	<input type="checkbox"/>	<input type="checkbox"/> Retirement accounts
<input type="checkbox"/>	<input type="checkbox"/> Keogh Plan	<input type="checkbox"/>	<input type="checkbox"/> Certificate of Deposit (CD)	<input type="checkbox"/>	<input type="checkbox"/> Trust funds
<input type="checkbox"/>	<input type="checkbox"/> Stocks or bonds	<input type="checkbox"/>	<input type="checkbox"/> Pension plans	<input type="checkbox"/>	<input type="checkbox"/> Other

— If you have **any of the above**, please provide the following information:

a.

Owner Name (last, first, middle initial)		Co-Owner Name (last, first, middle initial)	
Name of Bank or Institution	Account Type	Account Number	\$ Balance
Address of Bank or Institution			

b.

Owner Name (last, first, middle initial)		Co-Owner Name (last, first, middle initial)	
Name of Bank or Institution	Account Type	Account Number	\$ Balance
Address of Bank or Institution			

☐ YES ☐ NO 2. Has anyone sold, transferred or given away any resources in the last 3 months (for SNAP), in the last 3 years (for Auxiliary Grants)? If YES, explain: _____

Note: Additional Resource information may be needed section if you are applying for the Auxiliary Grant program.

C. INCOME

1. Do you or anyone who lives with you receive or expect to receive any of the following types of money from working? Include money from all jobs that you have now or expect to begin: full time, part time, seasonal, temporary, self-employment. Answer Yes or No below and provide the requested information:

Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/> Wages/Salary	<input type="checkbox"/>	<input type="checkbox"/> Earned Sick Pay	<input type="checkbox"/>	<input type="checkbox"/> Self-employment
<input type="checkbox"/>	<input type="checkbox"/> Contract Income	<input type="checkbox"/>	<input type="checkbox"/> Babysitting/Adult or child care	<input type="checkbox"/>	<input type="checkbox"/> Any other money from working
<input type="checkbox"/>	<input type="checkbox"/> Vacation Pay	<input type="checkbox"/>	<input type="checkbox"/> Farming/Fishing		
<input type="checkbox"/>	<input type="checkbox"/> Commissions, Bonuses, Tips	<input type="checkbox"/>	<input type="checkbox"/> Odd jobs		

Name (last, first, middle initial)	Employer Name, Address and Telephone Number
Number of Hours Per Week	Rate of Pay
Date Job Started	Next Pay Date (mm/dd/yyyy)
Name (last, first, middle initial)	Employer Name, Address and Telephone Number
Number of Hours Per Week	Rate of Pay
Date Job Started	Next Pay Date (mm/dd/yyyy)

INCOME (continued)

☐ YES ☐ NO 2. Has anyone been fired, laid off, gone on sick or maternity leave, gone on strike, quit a job, or reduced hours worked since you applied? If **YES**, give name and explain: _____

3. Do you or anyone who lives with you (including children) receive or expect to receive any of the following? Answer yes or no below and provide the requested information

Yes	No	Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/> Social Security	<input type="checkbox"/>	<input type="checkbox"/> VA benefits	<input type="checkbox"/>	<input type="checkbox"/> Strike benefits
<input type="checkbox"/>	<input type="checkbox"/> Child support, alimony	<input type="checkbox"/>	<input type="checkbox"/> Unemployment benefits	<input type="checkbox"/>	<input type="checkbox"/> Prize winnings
<input type="checkbox"/>	<input type="checkbox"/> Cash gifts or contributions	<input type="checkbox"/>	<input type="checkbox"/> Room/board income	<input type="checkbox"/>	<input type="checkbox"/> All food, clothing, utilities, or rent
<input type="checkbox"/>	<input type="checkbox"/> Loans	<input type="checkbox"/>	<input type="checkbox"/> Black Lung benefits	<input type="checkbox"/>	<input type="checkbox"/> Other retirement
<input type="checkbox"/>	<input type="checkbox"/> SSI	<input type="checkbox"/>	<input type="checkbox"/> Worker compensation	<input type="checkbox"/>	<input type="checkbox"/> Interest, dividends
<input type="checkbox"/>	<input type="checkbox"/> Military Allotment	<input type="checkbox"/>	<input type="checkbox"/> Rental Income	<input type="checkbox"/>	<input type="checkbox"/> Insurance settlement
<input type="checkbox"/>	<input type="checkbox"/> Public Assistance (TANF, GR etc)	<input type="checkbox"/>	<input type="checkbox"/> Inheritance	<input type="checkbox"/>	<input type="checkbox"/> Any other type of money
<input type="checkbox"/>	<input type="checkbox"/> Training allowances (WIA, etc.)	<input type="checkbox"/>	<input type="checkbox"/> Railroad retirement		

a.	\$		
Name of Person	Amount	Type of Money or Help	How Often Received?

b.	\$		
Name of Person	Amount	Type of Money or Help	How Often Received?

c.	\$		
Name of Person	Amount	Type of Money or Help	How Often Received?

☐ YES ☐ NO 4. Does anyone besides the people on your case pay directly for you, help you pay, or lend you money to pay rent, utilities, medical bills or any other bills? OR does anyone totally supply food, shelter or clothing for you or someone else on a regular basis? If **YES**, give name, amount, and explain: _____

☐ YES ☐ NO 5. Does anyone have a day care expense for a child, an elderly person, or an adult with a disability? If **YES**, give name, amount and explain: _____

☐ YES ☐ NO 6. Does anyone pay legally obligated child support to someone not in the household? If **YES**, give name of person paying, person supported, and amount: _____

D. FINANCIAL ASSISTANCE FOR CHILDREN

☐ YES ☐ NO 1. Has the absent parent(s) begun supporting the children or changed the amount of support?

If **YES**, explain: _____

☐ YES ☐ NO 2. Has the legal parent(s) become disabled such that he or she is unable to work? If **YES**, explain: _____

☐ YES ☐ NO 3. Do you have any new information that would help us locate the absent parent(s)? If **YES**, explain: _____

E. SNAP BENEFITS

1. List the name of the person who is the head of your household: _____
2. An authorized representative may apply for SNAP benefits on your behalf, receive and use your SNAP benefits on your behalf, or receive copies of your program notices. If you want to name an authorized representative, please give the information below about the representative and what you want the representative to do on your behalf.

Name, Address and Telephone Number of the Authorized Representative	Check (✓) each duty authorized for that person
	<input type="checkbox"/> Apply for SNAP benefits <input type="checkbox"/> Receive correspondence <input type="checkbox"/> Receive or use SNAP benefits

- ☐ YES ☐ NO 3. Is anyone living in your home NOT included in your SNAP application? If **YES**, do you and everyone for whom you are applying usually purchase and prepare meals apart from these people? Or, do you intend to do so if your application for SNAP benefits is approved? Check (✓) ☐ YES ☐ NO

- ☐ YES ☐ NO 4. Is anyone living in your home a roomer or boarder? If **YES**, list names: _____

- ☐ YES ☐ NO 5. Is anyone age 60 or older OR approved to receive Medicaid because of a disability OR receiving any type of disability payment? If **YES**, list all current medical expenses for these people.

Household Member with Medical Expense	Type of Expense	Amount	Name of Doctor, Hospital, Pharmacy

- ☐ YES ☐ NO 6. Do you have any of the following shelter expenses? If **YES**, list your current expenses. Check (✓) here ☐ if these expenses are for a house you do not live in.

Expense	Amount Billed	How Often Billed?	Who is Responsible for the Bill?
Rent/Mortgage			
Taxes			
Insurance			
Electricity			
Gas/Oil/Kerosene			
Coal/Wood			
Water/Sewage/Garbage			
Telephone			
Installation			

6a How do you heat your home? _____

- ☐ YES ☐ NO 6b Do you have air conditioning in your home?

- ☐ YES ☐ NO 6c Did you receive energy/fuel assistance during this past year while living in your current home?

- ☐ YES ☐ NO 6d Are you staying temporarily in someone else's home, an emergency shelter, welfare hotel, other halfway house, or a place not usually used for sleeping? If **YES**, how much does it cost to stay there during the month?

If you are staying temporarily in someone else's home, when did you move there? _____

USDA Nondiscrimination Statement

This institution is prohibited from discriminating on the basis of race, color, national origin, disability, age, sex and in some cases religion or political beliefs.

The U.S. Department of Agriculture also prohibits discrimination based on race, color, national origin, sex, religious creed, disability, age, political beliefs or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027), found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

- (1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
- (2) fax: (202) 690-7442; or
- (3) email: program.intake@usda.gov.

For any other information dealing with Supplemental Nutrition Assistance Program (SNAP) issues, persons should either contact the USDA SNAP Hotline Number at (800) 221-5689, which is also in Spanish or call the State Information/Hotline Numbers (click the link for a listing of hotline numbers by State); found online at: http://www.fns.usda.gov/snap/contact_info/hotlines.htm.

To file a complaint of discrimination regarding a program receiving Federal financial assistance through the U.S. Department of Health and Human Services (HHS), write: HHS Director, Office for Civil Rights, Room 515-F, 200 Independence Avenue, S.W., Washington, D.C. 20201 or call (202) 619-0403 (voice) or (800) 537-7697 (TTY).

This institution is an equal opportunity provider.

Commonwealth of Virginia Voter Registration Agency Certification

**If you are not registered to vote where you live now, would you like to apply to register to vote here today?
(Please check only one)**

- ☐ I am already registered to vote at my current address, or I am not eligible to register to vote and do not need an application to register to vote.
- ☐ Yes, I would like to apply to register to vote. (Please fill out the voter registration application form)
- ☐ No, I do not want to register to vote.

If you do not check any box, you will be considered to have decided **not to** register to vote at this time. Applying to register to vote or declining to register to vote will not affect the assistance or services that you will be provided by this agency. If you decline to register to vote, this fact will remain confidential. If you do register to vote, the office where your application was submitted will be kept confidential, and it will be used only for voter registration purposes. If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private if you desire.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, you may file a complaint with: Secretary of the Virginia State Board of Elections, Washington Building, 1100 Bank Street, Richmond, VA 23219-3497, telephone (804) 864-8901.

Applicant Name

Signature

Date

for agency use only

Voter Registration form completed:

☐ Yes ☐ No

Voter Registration form given to applicant for later mailing (at applicant's request) ☐

Agency Staff Signature

Date

VERIFICATION AND USE OF INFORMATION

Information you give on this application, including Social Security numbers (SSN), may be matched against federal, state, and local records. These records include:

- Virginia Employment Commission (VEC)
- Internal Revenue Service (IRS)
- Social Security Administration (SSA)
- Department of Motor Vehicles (DMV)
- US Citizenship and Immigration Services (USCIS)
- Income and Eligibility Verification System IEVS)*

* Information received through IEVS will be requested, used and may be verified through collateral contacts when discrepancies are found. The information may affect the amount of benefits and/or your continued receipt of benefits.

SNAP CHANGE REPORTING,

You must report changes that occur for SNAP but, what you must report is tied to how long you are determined eligible for benefits, the certification period. You must report changes that occur during the certification period within 10 days, but no later than the 10th day of the month after the change occurs.

Changes that need to be reported during the certification period for SNAP depend on the length of the certification period. "Simplified Reporting" applies to households that are eligible for SNAP benefits for five (5) months or longer. "Change Reporting" applies to households that are eligible for one (1) month to four (4) months.

INTERIM REPORT FILING

In addition to reporting changes when they occur during the SNAP certification period, Simplified Reporting households may be required to submit an Interim Report in the sixth or twelfth month. The Interim Report is used to determine the amount of SNAP benefits households will receive for the second half of the certification period. The Interim Report provides a snapshot of household circumstances that were presented at the time of application. We will ask for proof of income changes and changes in legal obligations to pay child support. If households fail to return the completed Interim Report by the fifth of the month, SNAP benefits for the seventh or thirteenth month may be delayed or closed. Assistance for filing the Interim Report is available by calling the telephone number printed on the form.

BY MY SIGNATURE BELOW, I DECLARE, UNDER PENALTY OF PERJURY, THAT THE INFORMATION PRESENTED HERE IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

I understand:

- All of my responsibilities, including my responsibility to report required changes on time.
- If I give false, incorrect, or incomplete information, or do not report required changes on time, I may be breaking the law and could be prosecuted.
- If I helped someone complete this form so as to get benefits he or she is not entitled to, I may be breaking the law and could be prosecuted.
- If I refuse to cooperate with any review of my eligibility, including reviews by Quality Assurance, my benefits may be denied until I cooperate.
- If my application is for SNAP, failure to report or verify of my expenses will be seen as a statement by my household that I do not want to receive a deduction for unreported expenses.

My signature authorizes the release to this agency of all information necessary to both determine and review my eligibility. This authorization is valid for one year from the date of my signature below. I understand that this time limit does not apply to investigations regarding possible fraud.

I filled in this application myself: ☐ Yes ☐ No

If NO, it was read back to me when complete: ☐ Yes ☐ No

Your Signature or Authorized Representative's Signature or Mark

Date

Witness to Mark or Interpreter

Date

Complete this section if this application was completed for the applicant by someone else.

Name of person completing application

Date

Relationship to applicant

Primary Telephone Number _____ Alternate Telephone Number _____

RENEWAL APPLICATION FOR AG, SNAP AND TANF

FORM NUMBER - 032-03-729A

PURPOSE OF FORM - To record a household's situation in order to renew or recertify eligibility.

USE OF FORM – This application is limited to renewal or recertification. This application may not be used in lieu of an application to apply for initial benefits, to reapply for benefits after a lapse in certification, or to protect the date of application. For AG, this application must be accompanied by Auxiliary Grant Supplemental Renewal Application (032-03-729C) to be a valid application.

NUMBER OF COPIES - One.

DISPOSITION OF FORM – This application must be completed at the time of the eligibility review. The completed application must be filed in the eligibility case record.

INSTRUCTIONS FOR PREPARATION OF FORM – The renewal application must be completed in its entirety, depending on the program requested. For example, the Resources section is needed for AG and SNAP but this section may be omitted for TANF renewals. For an application for AG only, the TANF and SNAP sections may be omitted.